

1 IN THE CIRCUIT COURT OF THE STATE OF OREGON
2 FOR THE COUNTY OF MULTNOMAH
3 The Estate of JESSE D.)
WILLIAMS, Deceased, by and)
4 through MAYOLA WILLIAMS,)
Personal Representative,) Volume 21-B
5)
Plaintiff,)
6)
vs.) No. 9705-03957
7)
PHILIP MORRIS INCORPORATED,) Afternoon Session
8)
Defendant.)

9
10 TRANSCRIPT OF PROCEEDINGS
11 BE IT REMEMBERED that the above-entitled
12 Court and cause came on regularly for hearing
13 before the Honorable Anna J. Brown on Monday, the
14 22nd day of March, 1999, at the Multnomah County
15 Courthouse, Portland, Oregon.

16 APPEARANCES

17
18 Raymond Thomas, James Coon,
William Gaylord and Charles Tauman,
Attorneys at Law,
19 Appearing on behalf of the Plaintiff;
20 James Dumas, Billy Randles, Walt Cofer
and Pat Sirridge,
21 Attorneys at Law,
Appearing on behalf of the Defendant.

22
23 KATIE BRADFORD, CSR 90-0148
Official Court Reporter
24 226 Multnomah County Courthouse
Portland, Oregon 97204
25 (503) 248-3549

S. Raffle - D

1 (Monday, March 22, 1999, 1:14 p.m.)

2 P R O C E E D I N G S

3 Afternoon Session

4 (Whereupon, the following
5 proceedings were held in
6 open court, the jury being
7 present:)

8 THE COURT: Good afternoon, Jurors.

9 Mr. Dumas.

10 MR. DUMAS: Thank you, Your Honor.

11

12 STEPHEN RAFFLE

13 Was thereupon called as a witness on behalf of the
14 Defendant and, having been previously duly sworn,
15 was examined and testified as follows:

16

17 FURTHER DIRECT EXAMINATION

18

19 BY MR. DUMAS:

20 Q. Dr. Raffle, I want to direct your
21 attention back to Mr. Jesse Williams. We talked
22 some about Mr. Williams' smoking pattern before.

23 By way of summary, if you will, Doctor,
24 based upon your education and your training and
25 your experience, sir, particularly that as it

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1 bears to substance dependency and addiction, and
2 based particularly on your review of the records
3 that pertain directly to Mr. Williams in this
4 case, sir, do you have an opinion, to a reasonable
5 medical probability, whether Jesse Williams could
6 have quit smoking?

7 A. I do.

8 Q. What is that opinion?

9 A. That he could have stopped smoking at any
10 time if he has chosen to.

11 Q. Did the nicotine in the cigarettes that
12 he smoked prevent him from deciding to quit or
13 from successfully quitting?

14 A. No.

15 Q. What is the basis of your opinion?

16 A. Basis is, as I said, background,
17 experience and training; that there was never a
18 time when he -- I don't know how to put this --
19 when he tried to stop smoking in an organized
20 fashion, where he would throw out his cigarettes,
21 set a quit date, throw out his ashtrays, or go to
22 his doctor, ask his doctor to help him set up a
23 program to stop smoking.

24 And when he was asked on the occasion of
25 whether or not he wanted to stop smoking by

S. Raffle - D

1 Dr. Kern, he said I'm going to think about it.

2 Q. Doctor, do you know for a fact whether it
3 was easy or in the middle or real hard for
4 Mr. Williams to quit?

5 A. I don't know.

6 Q. In reviewing the records, Doctor, did you
7 note that there were some of his family members
8 that quit?

9 A. Yes, I did. And I counted somewhere
10 between 10 and 12 family members who had quit at
11 different times.

12 Q. Is that significant to you as a
13 clinician, Doctor?

14 A. It is.

15 Q. Explain.

16 A. By having different family members who
17 was -- he knew, be able to quit, then he had a
18 role model on which to model his own behavior and
19 his own attempt.

20 Q. Doctor, based upon your review of the
21 records in this case, do you see -- can you
22 identify any reason or any basis to support a
23 belief that Mr. Williams was in any way less able
24 to stop smoking than the patients in your clinical
25 practice that chose to successfully quit?

S. Raffle - D/X

1 A. No. I have not found any peculiarities
2 or any special circumstance to account for any
3 greater than usual difficulty in stopping smoking.

4 MR. DUMAS: Thank you, Doctor. That's
5 all I have.

6 THE COURT: Cross-examination.

7 MR. THOMAS: Thank you, Your Honor.

8

9 CROSS-EXAMINATION

10

11 BY MR. THOMAS:

12 Q. Dr. Raffle, we haven't met before and I
13 don't believe I have ever had an opportunity to
14 examine your file. Do you have your file with you
15 today, sir?

16 A. Yes, I do.

17 Q. May I take a look at it?

18 A. Yes, it's over here.

19 Q. I guess one of the things that you had an
20 opportunity to look at before this case was done
21 was a condensed deposition transcript selection?

22 A. Yes.

23 Q. Who was it that condensed the depositions
24 for you? Did anyone condense the depositions for
25 you?

S. Raffle - X

1 A. I did that.

2 Q. You did it yourself?

3 A. Yes.

4 Q. Is there a resume or a curriculum vitae
5 in here somewhere?

6 A. No.

7 Q. All right. I think at some point before
8 too long we're going to have to take a short break
9 to get a technical person in here, and at that
10 time maybe I will look a little bit further in
11 here, but what I was really looking for is a CV.
12 Since I don't see one, maybe I'll just ask you a
13 few questions about your background.

14 I remember that you said the only time
15 you ever testified in a smoking case was a small
16 claims case, one that was insignificant enough
17 that there weren't even lawyers involved. Do you
18 remember that?

19 A. Yes.

20 Q. But that doesn't tell you the whole story
21 of your relationship with tobacco companies, does
22 it?

23 MR. DUMAS: Objection, argumentative,
24 Your Honor.

25 THE COURT: Overruled. Go ahead and

S. Raffle - X

1 answer.

2 THE WITNESS: Relationship? I don't
3 understand.

4 BY MR. THOMAS:

5 Q. Well, isn't it correct, sir, that you
6 have been involved with one tobacco company or
7 another as far back as 1984?

8 A. No, not '84.

9 Q. Well, it's true, is it not, that you have
10 been paid for submitting statements containing
11 your views about addiction and nicotine by at
12 least one tobacco company; actually, I guess, at
13 least two?

14 A. Yes.

15 Q. And do you remember when it was, the
16 first time that that was ever done?

17 A. Yes.

18 Q. When was that?

19 A. That was in 1988, when there were
20 hearings in Washington.

21 Q. And isn't it correct that you were
22 somebody who consulted with, was retained by,
23 transported and paid by one of the tobacco
24 companies or their trade association for your
25 involvement in that project; isn't that correct?

S. Raffle - X

1 A. Yes.

2 Q. Isn't it correct that your work has been
3 the subject of press releases by the tobacco
4 companies, or their trade association, The Tobacco
5 Institute?

6 A. I don't know.

7 Q. Well, I am going to show you and see if
8 this refreshes your recollection. Let's see, you
9 were retained by Brown & Williamson Tobacco
10 Company regarding addiction, were you not?

11 A. Yes.

12 Q. And I guess my -- maybe I have a bad
13 copy, but I thought it said it said 1984 on there;
14 is that incorrect?

15 A. I think it says 1994.

16 Q. All right.

17 A. It's certainly a bad copy, but it isn't
18 1984.

19 Q. All right. Were you aware that your name
20 was used in a Brown & Williamson press release in
21 May of 1994, and you were listed as an addiction
22 expert?

23 A. I wasn't aware of that, but I wouldn't
24 disagree with it.

25 Q. And were you aware that your name was

S. Raffle - X

1 used in 1988, as a California psychologist who I
2 guess disagrees with the Surgeon General on the
3 definition of addiction?

4 A. Yes.

5 Q. And were you aware that the Tobacco
6 Institute utilized your views in that way?

7 A. As far as a press release is concerned?
8 I wasn't aware of it, but it doesn't matter.

9 Q. All right. So it doesn't matter to you?

10 A. No.

11 Q. And in terms of something that the jury
12 may remember, the contact person for that 1988
13 Tobacco Institute press release was Walker
14 Merryman, isn't that right, Walker Merryman?

15 A. I don't recall who it was.

16 Q. Okay. And then again in 1994, it looks
17 like the Tobacco Institute used your work again;
18 is that right? Steven Raffle, practicing
19 physician.

20 A. Yes.

21 Q. And you've been the subject of some other
22 attention, have you not, from the press. In fact,
23 there was a Wall Street Journal story written
24 about you, wasn't there?

25 A. Yes.

S. Raffle - X

1 Q. You were named as being one of the
2 Tobacco Dream Team, weren't you?

3 A. I never read that article.

4 Q. Oh, you didn't?

5 A. No.

6 Q. Would you like to see it?

7 A. Yes.

8 Q. So you didn't see that one, huh?

9 "Tobacco Dream Team experts who insist
10 nicotine isn't addictive."

11 Were you aware of that story?

12 A. No. Is my name there?

13 Q. Yeah, I'll show it to you.

14 Would it be fair to say that the view
15 that tobacco is not an addictive substance is a
16 minority position in the drug treatment community?

17 A. I think it goes back to how the term
18 "addictive" is being used, which is what was I was
19 trying to explain earlier this morning.

20 Q. Okay. But would you agree with me that
21 it's a minority position within the drug treatment
22 community?

23 A. Maybe, I didn't make my answer clear. I
24 think that depending on how the term is being
25 defined that it would either be a minority view or

S. Raffle - X

1 not a minority view. I don't know if it is a
2 minority view or not a minority view.

3 All I know is what the pharmacology and
4 behavioral components of smoking are and nicotine
5 are, and trying to make them fit with my clinical
6 experience and training.

7 Q. Okay. Fair enough.

8 Here is your, "specialist in habit
9 forming pain killers, Dr. Raffle says, he
10 concluded that nicotine isn't addictive by
11 watching patients"?

12 A. Yes. In terms of as I explained today,
13 in terms of intoxication, withdrawal and
14 tolerance.

15 Q. All right. I think that you testified
16 that -- and I just wanted to kind of establish
17 this before we go any further. Your views are in
18 disagreement with the 1988 Surgeon General's
19 Report, correct?

20 A. I don't disagree that nicotine shares
21 properties of being highly controlled or having
22 behaviors which are not controlled or have
23 compulsive use or behaviors similar to what's
24 called drug reinforced behavior or having a
25 psychoactive effect.

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1 All I'm saying is that those are
2 properties of nicotine which are shared by many
3 non-addictive substances, and are more behavioral
4 than pharmacologic in nature. And that from a
5 practitioner's point of view, what is useful is
6 intoxication, tolerance and withdrawal.

7 Q. I am not --

8 A. So I --

9 Q. -- asking you about the content of your
10 views, but whether or not you're willing to admit
11 for purposes of your testimony today that your
12 views about addiction are inconsistent or in
13 disagreement with those of the United States
14 Attorney General, as contained in the 1988
15 report -- what did I say? Surgeon General, sorry.
16 As contained in the 1988 report?

17 A. No, I am not disagreeing with the Surgeon
18 General's identification criterion at all. I'm
19 saying that this -- that he has identified the
20 properties that nicotine has and that if he wants
21 to say that those constitute an addicting
22 substance, I can't say that he doesn't, not that
23 he is wrong. All I can say is that I find from a
24 clinical point of view it isn't of very much use.

25 Q. All right. Well, I guess I thought that

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1 you had made statements at previous times saying
2 that, in fact, your views are inconsistent with
3 those contained in the 1988 Surgeon General's
4 Report?

5 A. I don't know how I have been quoted. I
6 do know what I have testified to today.

7 Q. All right.

8 A. And that's what I believe.

9 Q. Okay. Well, now, one of the main
10 differences in terms of your testimony as opposed
11 to what is contained in the Surgeon General's
12 Report, and you know Dr. Benowitz testified in
13 this case and you read his testimony, correct?

14 A. Yes, I did.

15 Q. You know that then at least a way that
16 your testimony is in disagreement with the view in
17 the report is that you believe that equating
18 nicotine with hard drugs, like heroin or cocaine.
19 For purposes of using the word addiction is
20 incorrect. Isn't that a fair statement?

21 A. Incorrect? I think that, you know, there
22 are many properties that -- I don't know how to
23 answer your question. Maybe you could restate it.

24 Q. All right. Well, let me try, instead of
25 getting into what I know are preliminary

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1 questions, let me get more specific and I think
2 that may make it easier.

3 A. Okay.

4 Q. It's correct, is it not, that you are not
5 a person who is presently on any committee
6 studying drug abuse or drug addiction, involved in
7 any research project with any drug abuse or drug
8 treatment organization at the present time?

9 A. Correct.

10 Q. And is it also fair to say that you not
11 involved in any study about drug abuse at the
12 present time?

13 A. Yes.

14 Q. And is it also fair to say that you have
15 not written any articles or studies that have been
16 published in any peer review literature,
17 containing the views that you stated today, so
18 that your colleagues can have an opportunity to
19 review and comment upon your beliefs?

20 A. Correct.

21 THE COURT: Mr. Thomas, would you
22 approach, please.

23 MR. THOMAS: Could we take a brief --

24 THE COURT: Sure, how brief?

25 We have a little technical thing

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1 happening here, Jurors. If you just want to sit
2 at ease, I think we may be able to solve this
3 problem without having to have you step out to
4 the jury room. Feel free to stretch and
5 disregard the technical work you see going on
6 right now. We're off the record.

7 (Pause in proceedings.)

8 THE COURT: All right. We're back on the
9 record.

10 MR. THOMAS: Thank you, Judge.

11 BY MR. THOMAS:

12 Q. All right. Let's go back to my attempt
13 to find out what authority there is for your
14 views, that's what I'm going to ask you the next
15 few questions about, okay?

16 You are aware, are you not, that a number
17 of organizations include nicotine as a drug that
18 qualifies for either the label of addictive or
19 dependency producing, are you not?

20 A. Yes, I am.

21 Q. And would you agree with me that they
22 include the Food & Drug Administration of the
23 United States?

24 A. I don't know if the FDA does, but I think
25 they do.

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1 Q. American Cancer Society?

2 A. Again, I don't know.

3 Q. How about the World Health Organization?

4 A. They do.

5 Q. Are you a member -- you said you use the
6 DSM-IV; is that right?

7 A. Correct.

8 Q. And what organization puts the DSM-IV
9 out?

10 A. The American Psychiatric Association.

11 Q. Are you a member of the American
12 Psychiatric Association?

13 A. I am.

14 Q. Do you know whether or not they choose to
15 include nicotine within either addictive or
16 dependency-producing substances?

17 A. They say that it may be dependency
18 producing.

19 Q. They not only say it may be dependency
20 producing, they say it can be and is dependency
21 producing for some people, correct?

22 A. That's what I said.

23 Q. And isn't it also correct that you are in
24 disagreement with your own organization about that
25 view; isn't that right?

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1 A. No, it isn't right. What I'm saying is
2 that if you use the definition that they are
3 using, then I would agree with them that it may
4 cause dependency in some people. I don't disagree
5 with them at all.

6 Q. And what about addiction?

7 A. They don't use the term "addiction."

8 Q. Okay. What about the American Lung
9 Association, do they believe that nicotine can be
10 addictive or dependency producing?

11 A. I don't know.

12 Q. What about the American Heart
13 Association?

14 A. I don't know.

15 Q. How about the National Institute of
16 Health?

17 A. I have not seen anything from them.

18 Q. Well, you just don't know one way or the
19 other?

20 A. That's correct.

21 Q. Wouldn't it be fair to say that under
22 your view of dependency producing or addiction, it
23 would be likely that people would think that
24 nicotine has less affect on a person's individual
25 ability to stop using it once -- it would have an

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1 impact on people's view of a person's ability to
2 stop using nicotine once they become addicted to
3 it?

4 A. I'll have to ask you to repeat the
5 question because I think I understand what you're
6 saying, but I don't want to make a mistake.

7 Q. Okay. Well, isn't it right that from I
8 guess kind of a common sense perspective that
9 somebody who doesn't believe that nicotine can be
10 addictive for some people is going to create a
11 different view of an individual's ability to quit
12 using nicotine, once they became habituated to it,
13 then somebody look believes that nicotine is and
14 can be addictive?

15 A. I think I got your question. I'll kind
16 of restate it and then answer it.

17 Q. Okay.

18 A. I am not disagreeing with the American
19 Psychiatric Association's definition of nicotine
20 dependency, or nicotine withdrawal. I am not
21 disagreeing with it at all.

22 Q. Okay.

23 A. And I'm saying that if that's the
24 definition they are going to use, I am not in a
25 position to say that they're right and or wrong,

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1 although I may have some different opinions in
2 terms of where the emphasis is.

3 From my point of view as a clinician,
4 both my experience as a clinician and from what
5 the literature says, it doesn't make one bit of
6 difference if you diagnose a person with nicotine
7 dependence or nicotine withdrawal in terms of
8 predicting whether or not the person can
9 successfully stop smoking.

10 The diagnosis of nicotine dependence
11 doesn't determine whether a person can stop or
12 not. The person is just as likely to stop smoking
13 with a diagnosis of nicotine dependence or without
14 a diagnosis of nicotine dependence, but the
15 diagnosis is of no value clinically regarding
16 smoking cessation.

17 Similarly, if you are one of the 20 to 50
18 percent of people who have nicotine withdrawal, it
19 doesn't matter if you have nicotine withdrawal as
20 part of smoking cessation. It is just as easy to
21 stop smoking if you have nicotine withdrawal than
22 if you don't have nicotine withdrawal.

23 That is not just my opinion. There
24 are -- there is literature on that fact. And so
25 the diagnosis of nicotine dependence or nicotine

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1 withdrawal may have certain criteria, but it
2 doesn't predict -- it's not a variable in terms of
3 successful quitting. That's what I said.

4 Q. I'm sorry, but I'm having trouble finding
5 the answers to my questions in your answers.

6 Let me ask you this, sir, do you think
7 that your views about nicotine dependence and
8 addiction might have something to do with why it
9 is that Philip Morris Tobacco Company decided to
10 bring you into this court to testify today about
11 this subject matter?

12 MR. DUMAS: Objection, your Honor,
13 argumentative.

14 THE COURT: Sustained.

15 BY MR. THOMAS:

16 Q. Let's talk about some of the things that
17 I think you said to me. Is it right to say that
18 you don't disagree with the American Psychiatric
19 Association's DSM-IV?

20 A. Correct.

21 Q. Okay. Now, I think you said some things
22 and maybe the easiest way for me to do this is to
23 look at your charts. Now, when you talk about
24 what you call the -- what did you call your view
25 as opposed to the academician's view, the

S. Raffle - X

1 clinician's view?

2 A. Practitioner's.

3 Q. The practitioner's view.

4 A. Criteria.

5 Q. Is there any association for the study of
6 drug dependence for the treatment of drug
7 disorders or scientific research about how people
8 do become addicted to different things that
9 supports your view that you call the
10 practitioner's view, where I can go to a textbook
11 or a current study or organization and say, "Oh,
12 well, here it is. Here is what he said. Here's
13 the body of scientific research. Here is the
14 organizational affiliation with the things that he
15 has to say." Is there one?

16 A. Only as contained within the over --
17 let's see, my answer is kind of convoluted as your
18 question. I'm going to try to keep it not.

19 My clinical experience and the clinical
20 experience of my colleges is how I based the
21 practitioner's criteria. It derives from the '64
22 Surgeon General's definition. I don't know how
23 else to say it.

24 Q. I think you're doing fine.

25 Now, when you say that it derives from

S. Raffle - X

1 the 1964 Surgeon General's Report, that is the
2 Surgeon General's Report that is now 35 years old,
3 right?

4 A. Correct.

5 Q. And when you talk about me and my
6 colleagues, well, who in -- aside from the other
7 members of the Tobacco Dream Team -- who is within
8 this "my colleagues" description, which is a
9 legitimate organization involved in drug
10 treatment, study of scientific research relating
11 to drug addiction or general medical treatment of
12 people who have drug disorders?

13 A. I don't understand your question, sir.

14 Q. Well, you talk about "my colleagues."
15 Are you a member of some group that espouses or
16 says that these views that you gave the jury this
17 morning, that these are the guidelines of this
18 legitimate organization? Do you have one you can
19 point to and tell us, "Look at that," and that's
20 where your views are contained, a practitioner's
21 organization?

22 A. Now I understand your question. There is
23 no practitioner's organization, if you will. What
24 I'm talking about is that my clinical experience
25 and the clinical experience of the colleagues with

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1 whom I practice, with the orthopedists and the
2 psychiatrists whom I know and with whom I speak,
3 find that intoxication, tolerance and withdrawal
4 are what's operational in treating drug addiction.

5 Q. Okay. Well, let me just ask you, I am
6 going to try to ask you as straight a question as
7 I can.

8 A. Okay.

9 Q. Isn't it fair to say that there is no
10 legitimate organization with bylaws, with
11 scientific research, that you can point to,
12 besides what you think and what these colleagues
13 that you talk about think, as scientific medical
14 support for your views about addiction?

15 A. In terms of definitions, no.

16 Q. Thank you. Now, let's go to your views
17 about addiction. Well, let's just start with one
18 thing and maybe we can get past this, too.

19 Don't you think it is a little bit unfair
20 to say that there is the practitioner's criteria
21 on the one side, and on the other side there is
22 the academicians when really, as far as what is
23 published in the scientific and medical research
24 and literature, there really isn't some
25 practitioner's criteria. That is something that

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1 you have brought here based upon your own personal
2 views and those of your colleagues, these people
3 that you talk about that you talk to, right?

4 A. Correct.

5 Q. Isn't that a little bit sort of unfair to
6 kind of make it seem like there is you and you're
7 the practitioner, but then everybody else who has
8 done anything in this area and really put it out,
9 well, they're all the academicians. Do you think
10 that is a little bit unfair?

11 MR. DUMAS: I think that is
12 argumentative, Your Honor.

13 THE COURT: Overruled.

14 Mr. Thomas, the jurors on this side can't
15 see the chart you're using.

16 MR. THOMAS: Okay.

17 THE WITNESS: No. I don't think it is
18 unfair because I explained how I came to making
19 that separation. And I also used other displays
20 to show the DSM-IV's criteria, and another
21 display to show the Surgeon General's criteria.

22 BY MR. THOMAS:

23 Q. Well --

24 A. So as long as I have explained the
25 criteria, I think that is fair.

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1 Q. Okay. Maybe we should go to the DSM. I
2 am sorry that I have to go back through these
3 things, but let's see how we should do it. Let's
4 do it this way.

5 Now, you told the jury this morning that
6 there were a number of things that were required
7 for a clinically significant impairment; is that
8 right?

9 A. No. What I said is that there must be
10 three or more of the following to be severe enough
11 to cause clinically significant impairment or
12 distress for a substance to be said to have
13 substance dependence, for a person to have
14 substance dependence.

15 Q. Okay. Well, let's please come over here
16 and let's just put this up.

17 A. (The witness complies.)

18 Q. Here we go. Let's see, have you got a
19 pointer? Why don't you get the pointer, would
20 you? Do you see it there in the corner?

21 A. (The witness complies.)

22 Q. Now this relates to the DSM-IV, right?

23 A. Yes.

24 Q. And the DSM-IV is this book, right?

25 A. Right.

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1 Q. This is sort of the Bible, isn't it?

2 A. No, but it's a book.

3 Q. Well, it's the Bible of diagnostics for
4 mental health, isn't it?

5 A. It is not close to a Bible. It is being
6 revised all the time.

7 Q. Okay. Fair enough.

8 And what you said was one of the things
9 that is required is persistent tolerance and then
10 you put a bracket, ever-increasing need for more
11 of the substance?

12 A. Correct.

13 Q. Now, do you think that is really a fair
14 way to describe what persistent tolerance is in
15 the DSM-IV?

16 A. Yes, I think that's how it's described.

17 Q. And doesn't that make it seem like if a
18 person was going to be included within substance
19 dependence under the DSM-IV, well, gosh, if they
20 were a tobacco smoker, they would always have to
21 want more and more and more and more of it; isn't
22 that right? That's a fair inference to be raised
23 from what you told the jury?

24 A. That is the classical use of the word
25 "tolerance." It has been redefined, of course,

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1 for nicotine.

2 Q. By whom?

3 A. By the DSM-IV.

4 Q. But you didn't tell the jury that, did
5 you?

6 A. I explained to them what persistent
7 tolerance means and the use of classical drug
8 abuse. I said that nicotine does not behave like
9 other drugs as far as the development of tolerance
10 and that there is a difference between tolerance
11 as it relates to classical drugs and being able to
12 tolerate side effects which is how DSM-IV treats
13 tolerance for nicotine.

14 Q. Okay. Well, let's just make sure we're
15 talking before the same DSM-IV, right?

16 A. Correct.

17 Q. All right. Now, I am going to direct
18 your attention, and you can see it over here, and
19 this is Page 176, Counsel, and this is going to
20 take a couple of minutes, but I just think it is
21 important.

22 This is the section on tolerance, isn't
23 it, right here, right?

24 A. Yes, let me step over.

25 THE COURT: Doctor, if you'll stand over

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1 to this far side of the monitor, then you can
2 see it and the jurors can see it as well. Thank
3 you.

4 BY MR. THOMAS:

5 Q. All right. Now, I am going to have to be
6 here.

7 A. Okay.

8 Q. But you can be there.

9 A. Okay.

10 Q. I'm going to read it and you tell me if I
11 get it right, okay?

12 A. Uh-huh.

13 Q. Tolerance, criterion one, oh, too little.
14 I don't know what I can do to make it better.

15 Better? Well, that's better. How about that?

16 A. Good.

17 Q. Okay. Let's just read it to the jury.

18 "Tolerance, criterion one, is the need for greatly
19 increased amounts of the substance to achieve the
20 intoxication or the desired effect or a markedly
21 diminished effect with continued use of the same
22 amount of the substance."

23 Now, you didn't choose to put that in the
24 bracket on your chart, did you?

25 A. No, I put that in my explanation.

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1 Q. Okay. And in fact, it goes on to
2 actually describe how it applies to smokers.

3 "Many individuals who smoke cigarettes
4 consume more than 20 cigarettes a day, an amount
5 that would have produced symptoms of toxicity when
6 they first started smoking."

7 A. Correct. And that's tolerating the side
8 effects of nicotine.

9 Q. And isn't it correct, sir, when you
10 decided to list the criteria for substance
11 dependence, you did not choose to use those which
12 applied to that topic for which you were called
13 here today, nicotine, correct?

14 A. I explained that tolerating the side
15 effects of nicotine is different than of an
16 ever-increasing need for more of the substance.

17 Q. All right. Go ahead. Go ahead and
18 explain it.

19 A. I know. Or that after you have used the
20 substance for a long time, at the same level
21 you're no longer getting the same effect. Since
22 intoxication doesn't occur with nicotine, that
23 particular criteria doesn't exist either for
24 nicotine. So the only way you can say that
25 tolerance develops in nicotine is to say the

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1 people who smoke tolerate the side effects.

2 Q. Do you think it was really fair to
3 include this part of it, but not the part that's
4 specifically related to nicotine in your chart?

5 A. I explained it to them.

6 Q. Okay. And the other thing, I think that
7 you said, if you could just stay here with me,
8 please, characteristic withdrawal symptoms.

9 A. Yes.

10 Q. You are saying there aren't really
11 withdrawal symptoms that are powerful for
12 nicotine, correct?

13 A. Correct.

14 Q. Okay. Now, let's talk about what you got
15 to see before you testified here today. Did you
16 get to see any of the internal Philip Morris
17 documents that were previously secret until they
18 were unveiled to the public as a result of a Court
19 order?

20 A. No.

21 Q. All right. So you haven't seen those.
22 Okay. So I am not going to ask you about those.
23 But nobody from the tobacco company ever -- strike
24 that.

25 Nobody from the tobacco company ever came

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1 up to you and said, "You know, Dr. Raffle, before
2 you go testifying in court, maybe you better know
3 what our own studies going back to the '50s and
4 the '60s and the '70s have shown us about nicotine
5 addiction and nicotine use."

6 MR. DUMAS: Objection, asked and
7 answered.

8 BY MR. THOMAS:

9 Q. No one ever told you that?

10 THE COURT: Remember me? Objection
11 sustained.

12 MR. THOMAS: I'm sorry.

13 BY MR. THOMAS:

14 Q. Okay. None of the lawyers who prepared
15 you today told you that they thought maybe you
16 ought to see some documents from inside Philip
17 Morris before you testified?

18 MR. DUMAS: Objection, argumentative.

19 THE COURT: I'm sorry.

20 MR. DUMAS: It's argumentative.

21 THE COURT: It is argumentative.

22 Objection sustained.

23 BY MR. THOMAS:

24 Q. Did any of the lawyers who prepared you
25 to testify today say perhaps you ought to see some

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1 internal documents before you testify in front of
2 this jury?

3 A. No.

4 Q. Now, in terms of Philip Morris' own
5 documents that aren't separate, let's see if you
6 know about what has come to be known, and this is
7 Plaintiff's Exhibit 81, as the study after the
8 quit smoking movie, remember in Iowa, called Cold
9 Turkey? Did you know about that movie, Cold
10 Turkey? It was a movie about people in Iowa who
11 quit smoking, it was back -- I think it was in the
12 '60s or early '70s?

13 A. No, I didn't.

14 Q. No? I am going to represent to you that
15 in 1971, there was a Philip Morris study that was
16 done in that town eight months after the movie was
17 made. What it did was it studied people who had
18 not tried to quit and people who had tried to quit
19 and people who had never smoked.

20 And I'm going to show you and this is,
21 Counsel, on Page 32, and please if you could go
22 over to that monitor over there, I am going to put
23 it on there. I am going to show you Table 14.
24 This is something that Philip Morris did.

25 Now, it's a little difficult to

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1 understand at first, and, Bill, tell me now when I
2 get to the point where I have as much of it on the
3 viewer as I can. How about that?

4 MR. GAYLORD: That's about it.

5 BY MR. THOMAS:

6 Q. Okay. There is a little bit of coating
7 here, but there is NEBS, those are the never tried
8 to quit, the BTTQ are the try to quit, and the
9 ALFF, those are the folks who quit but they
10 weren't smoking eight months after study.

11 These are the percentage of people who
12 report these problems. And I'm going to ask you,
13 sir, if these are significant withdrawal symptoms
14 for people who in this column have, eight months
15 ago, quit. Trouble sleeping, not a problem.

16 A. Excuse me.

17 Q. Yes.

18 A. I need to know how -- because in any
19 scientific periodical or journal article, they
20 would give some measure of what they meant by
21 restless and tense. In other words, is this
22 self-report, or is this using psychological
23 testing? What are the symptoms of restless and
24 tense? What are the symptoms of ill tempered and
25 loss of energy? How did they come to that,

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1 please?

2 Q. I will represent to you, and I'll give
3 this question to you in a hypothetical form, but
4 these are self-reporting by the people who
5 actually did it. And what I have done is I have
6 taken a yellow highlighter and gone to those
7 symptoms which eight months afterward were
8 significantly elevated above people who had never
9 smoked.

10 Restless and tense, 11 percent who never
11 tried to quit -- or never smoked, I'm sorry; 17.3
12 for people who didn't try to quit; 39.4, double
13 the amount of people who don't try to quit and
14 people who had quit report restless and tense.
15 This all going to go to a particular question,
16 okay?

17 A. Okay. But I need to ask a question,
18 though.

19 Q. All right.

20 A. And that is do we know on a relative
21 scale, let's zero to ten, how much -- what was the
22 degree of the restlessness and tension?

23 Q. No, we don't. We just know that those
24 people felt that it was enough of a change that
25 they reported it.

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1 A. Okay. Thank you.

2 Q. Blue or depressed from the people who had
3 never smoked, 10 percent to 25 percent in those
4 who had quit. Ill tempered, from 5.7 in the
5 people who never quit -- or never smoked, to 36
6 percent after eight months.

7 Loss of energy from 12 in the people who
8 had never smoked to 25 percent, double in the
9 people who quit. Apt to dose off, from 15.7,
10 double, 29.6. Trouble concentrating, 10 to 13.8,
11 not so bad.

12 Constipation. Maybe it sounds kind of
13 funny, but if a person has constipation it can be
14 a serious problem for them in getting their day
15 going, can't it?

16 A. Certain things going.

17 Q. 4.8 up to 27.3 eight months after they
18 quit. And then the final one, weight gain. 10.8,
19 reported that they had problems with weight gain,
20 the people who had never smoked, but 64.9 reported
21 that they had problems with weight gain.

22 I'm going to ask you, sir, if these
23 numbers are correct, and I'm going to represent to
24 you that they come out of Philip Morris' own
25 study, don't you think that this would show some

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1 fairly significant elevated levels of
2 self-reported problems as much as eight months
3 after they quit smoking cigarettes?

4 A. Let me answer that with a comment and
5 then I'll give you an answer. I don't have any
6 quantitative statement in this study about but how
7 much more restless and tense they were. Let's
8 take weight gain, for example. That's got the
9 highest change.

10 What I do know from the literature is
11 that there is weight gain of between two and ten
12 pounds after people stop smoking. I also know
13 that the literature indicates that when a person
14 starts smoking, there is a weight loss of probably
15 about five pounds. So when you smoke, you lose
16 weight. And when you stop smoking, you regain the
17 weight that you had loss when you started smoking.

18 So the notion that there is a weight gain
19 here, for example, in terms of quantity, we have
20 to look at it in terms of the seriousness which
21 has no quantification there. And then when you
22 look at the other data says regarding weight gain,
23 since that it is most prominent one, you have to
24 look at the people who were smoking. What was
25 their state of affairs before they started

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1 smoking?

2 And then after they gave up smoking, did
3 they return to the way they were before they
4 started smoking or didn't they? And there is
5 nothing here to indicate that. So the notion that
6 they're more restless and tense, for example, they
7 might have been restless and tense people whose
8 smoking caused them a greater sense of
9 satisfaction and calmness.

10 So they stopped smoking and they become
11 the kind of restless and tense person, the more
12 restless and tense person they were afterwards as
13 they were when they were smoking, but the same as
14 they were before they started smoking.

15 Q. Could I --

16 A. Similarly with depression, that sometimes
17 a person who is -- I mean there is good data in
18 cigarette smoke. There is a monoamine oxidate,
19 like an anti-depressant. People who stop smoking
20 very commonly -- and I mentioned this in my direct
21 testimony -- have some problems with enduring
22 depression that can go on for six months.

23 But there is -- there has been
24 indications that the use of bupropion, which is a
25 betaine, will help that group of people deal with

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1 the depression that seems to have been partly
2 addressed by the smoking itself. And it probably
3 has some biological effects.

4 So the problem with the study is it's
5 completeness and it's -- and the looking at the
6 smokers who, you know, where they were before they
7 started in the first place.

8 Q. Okay.

9 A. Should I stand or go back to the witness
10 stand?

11 Q. Let's see, actually, if you could stay
12 there, I have a few more questions that I'm going
13 to ask you. Have you appeared on any television
14 shows?

15 A. No.

16 Q. In connection -- or interview shows or
17 have you been interviewed by any news
18 organizations in connection with your views?

19 A. No. I gave a brief interview for NPR
20 some years ago.

21 Q. And was that NPR, on radio or talk radio
22 or news radio?

23 A. Correct.

24 Q. And that was about your views on
25 addiction?

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1 A. Correct.

2 Q. Now, you said that one of the things, I
3 think, that would be -- and I'm sorry I am going
4 to jump around a little bit, but you said one of
5 the things that using the word "addiction" or a
6 "nicotine user" would be to tend to self-defeat
7 their attempts to quit. Remember this morning?
8 They would sort of have a victim mentality.

9 A. I don't believe I said that this morning.

10 Q. Well, do you believe using the word
11 "addict" or "addictive behavior" connected with
12 nicotine use is something that is going to help or
13 hurt people trying to quit?

14 A. I think that it can both help or hurt the
15 person, depending on the person; that it has --
16 there are some times the rule of unintended
17 consequences. That is, if you tell a smoker that
18 they're addicted to nicotine and it creates for
19 the smoker a burden in terms of their
20 self-efficacy or psyche.

21 If you think you're addicted to
22 something, it makes it harder to stop it in most
23 people's minds than if you don't think you're
24 addicted. So since self-efficacy is one of the
25 two variables that predicts successful quitting,

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1 telling a person that they are addicted might
2 create a burden in some people's minds regarding
3 that.

4 On the other hand, telling a person that
5 their addicted to nicotine might motivate them to
6 try to stop doing something or not starting in the
7 first place. So it's not a simple -- you can't
8 simply say that labeling something as addictive
9 only has a good consequence. There can be
10 unintended consequences.

11 Q. Isn't it also true that if a person were
12 to realize that they were addicted to nicotine if
13 they were, they could have the positive result of
14 people who are alcoholics, such as people that go
15 to AA meetings. And what is the first thing that
16 they say? They say, "My name is John and I'm an
17 alcoholic."

18 That helps them deal in a realistic way
19 with a big problem that they've got. That is a
20 possible consequence of somebody realizing that
21 they're an addict, isn't it?

22 A. That is one possible consequence if
23 they're in a behavioral group. I think that it is
24 more important to tell them other things about
25 nicotine and the fact that being habituated or

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1 addicted to it has nothing to do with the outcome
2 of their quitting.

3 Q. Okay. I would like to ask you a
4 hypothetical question, sir, based upon the DSM-IV
5 substance dependence. If Jesse Williams had the
6 kind of persistent tolerance that was described in
7 the DSM-IV that I read to the jury.

8 A. And that he has no side effects from the
9 nicotine.

10 Q. Right. Such as he would have if he would
11 have been someone who didn't use it at all.

12 A. Okay.

13 Q. If he had a characteristic withdrawal
14 syndrome as a result of trying to quit based upon
15 his great discomfort, irritability, being beside
16 himself, unable to quit.

17 A. I'm sorry, beside himself?

18 Q. Beside himself, extremely uncomfortable
19 and unsettled.

20 If he was involved in unintended extended
21 use, such that sometimes his family members would
22 describe him lighting up two cigarettes, chain
23 smoking. If he had unsuccessful efforts to
24 control his use, if he devoted an extensive amount
25 of his free time and his time when he was not on

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1 task at work to cigarette smoking, if he gave up
2 important social and recreational activities, so
3 that he could take a smoke, being with his kids to
4 watch a game and having to go out and miss a big
5 play, or being with his wife in bed watching a
6 movie and having to go out and smoke.

7 And if he used it despite the
8 availability of knowledge about adverse health
9 consequences such as cancer --

10 A. Uh-huh.

11 Q. -- do you believe, based on that
12 hypothetical, that Jesse Williams would at least
13 be a person who would be close to the level of
14 substance dependence under the DSM-IV?

15 A. He might be.

16 Q. Okay. Now, you said some things about a
17 comparison between nicotine, caffeine and heroin,
18 right? And one of the things that you said in
19 this chart, which was Exhibit 960, was that while
20 heroin resulted in intoxication, neither caffeine
21 nor nicotine did?

22 A. Correct.

23 Q. Correct? You are aware, are you not,
24 that a high dosage of caffeine, unlike nicotine,
25 can actually result in intoxication, are you not?

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1 A. It can, yes.

2 Q. And isn't it true that the position, now
3 this is your opinion here, right?

4 A. Correct.

5 Q. It is not based upon some other
6 guidelines somewhere, right?

7 A. I had articles I relied on also regarding
8 caffeine and nicotine and heroin.

9 Q. Well --

10 A. There is data I have drawn on, not just
11 my own experience.

12 Q. Well, you are aware, are you not, that in
13 terms of high dosages of caffeine relevant to
14 nicotine, while a person doesn't become
15 intoxicated on nicotine, a person can actually
16 ingest enough caffeine to become intoxicated,
17 right?

18 A. Anything is possible. But when a person
19 is using caffeine in the usual manner, they're not
20 intoxicated. I hope my testimony earlier today
21 was talking about the usual coffee drinker as
22 compared to the usual heroin user and the usual
23 smoker.

24 Q. But your view here is contrary to the
25 DSM-IV, is it not?

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1 A. With high doses of caffeine, you can get
2 intoxication.

3 Q. Thank you. So your chart is inconsistent
4 with the DSM-IV chart on the same subject, isn't
5 it?

6 A. If you want to argue about that, I
7 wouldn't disagree.

8 Q. You wouldn't disagree. All right. Thank
9 you.

10 Now, in regard to tolerance, you say
11 heroin produces tolerance, but you don't say
12 anything about nicotine producing tolerance.
13 Isn't it true, sir, that your view about the
14 tolerance to nicotine is inconsistent with the
15 view taken in the DSM-IV in regard to tolerance?

16 A. I think -- well, it may be.

17 Q. It may be. Well, let's just make
18 certain. You're aware that there is a diagnostic
19 chart in the DSM-IV, are you not?

20 A. Yes.

21 Q. And are you able to say, so we can move
22 on to the next that, in fact, nicotine is viewed
23 as producing tolerance in its users by the DSM-IV,
24 and that's not what you put on the chart?

25 A. Correct, and I explained why.

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1 Q. Okay. And isn't it also true in terms of
2 your chart that you say that people who have --
3 who are regular users of caffeine have physical
4 withdrawal?

5 A. Yes, and I said also with nicotine.

6 Q. Well, you didn't put it on your chart,
7 though, did you?

8 A. No, but I did it in my testimony. I
9 could put it in now.

10 Q. Well, sir, do you want to draw a check
11 mark there under physical withdrawal just to make
12 it consistent?

13 A. Right. The lower heart rate would be a
14 physical symptom.

15 Q. But you're not going to acknowledge that
16 there are other withdrawal symptoms for some
17 people who try to quit smoking, right?

18 A. I am saying physical withdrawal as
19 opposed to behavioral.

20 Q. Well, is constipation a physical
21 withdrawal?

22 A. It is not considered in the DSM-IV.

23 Q. So, it's your view then that caffeine has
24 physical withdrawal symptoms for the regular
25 drinker of coffee?

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1 A. Headaches, yes.

2 Q. Now, you know, don't you, sir, that that
3 is inconsistent with what the DSM-IV says?

4 A. What does it say? Excuse me, sir. I am
5 not going to argue with you. I didn't say that I
6 relied on this chart or that I relied on the
7 DSM-IV. I relied on Dr. Benowitz's articles on
8 caffeine withdrawal and articles of John Hughes.

9 Q. Well, let's just tell the jury straight
10 up whether, in fact, caffeine is listed as
11 something accompanied by any withdrawal
12 whatsoever?

13 A. Not in DSM-IV, but in those articles, it
14 does.

15 Q. And isn't it correct, sir, that nicotine
16 is?

17 A. Yes, and I've already explained that.

18 Q. Don't you think that the way that you did
19 this was a little bit unfair?

20 A. No.

21 Q. Now, you said that people's actions in
22 terms of quitting smoking speak louder than words.
23 Remember that?

24 A. Did I? I don't know if I did. I
25 wouldn't disagree with it.

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1 Q. I remember, I think you did. And the
2 reason I asked you about that is you said that you
3 read the testimony of Michael Williams who
4 testified in this case to this jury?

5 A. Yes.

6 Q. And I think that you told them that Jesse
7 Williams never went through the kinds of things
8 involved in a declaration to quit that you would
9 associate with somebody who is making an honest,
10 genuine effort. Do you remember that?

11 A. I said in the medical records there is no
12 evidence that that ever occurred.

13 Q. Well, sir, you noticed, did you not, when
14 you looked at the medical records that in 1989
15 Jesse Williams got prescribed for himself some
16 Nicorette gum, did you not?

17 A. Yes.

18 Q. That is associated with a person's effort
19 to get rid of their nicotine usage, isn't it?

20 A. That's part of it, but it also requires,
21 as the directions say, that the individual is
22 supposed to go into a behavioral program to assist
23 them with the smoking cessation. And I am not
24 sure, but it may say that a failure to do so means
25 that the use of the gum in and of itself will not

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1 be effective.

2 Q. But isn't it also true that you don't
3 tell your patients that they need to get into a
4 behavioral program. You tell them that the way to
5 quit is to declare yourself that you are going to
6 quit.

7 A. I am a behavioral program.

8 Q. Fair enough. I'm not going to disagree
9 with that; but, sir, are you aware that Michael
10 Williams testified to the jury that when he came
11 over to the house after Jesse Williams got the
12 Nicorette gum, he looked on the kitchen table, and
13 there, instead of the Marlboros or the Marlboro
14 Lights that he expected to see, was the Nicorette
15 gum?

16 A. Yes.

17 Q. Yeah. And don't you think that it's fair
18 to say that that would be associated with the
19 declaration that a person intends to quit, when
20 they get rid of their cigarettes and they put
21 their Nicorette gum in the place that is their
22 accustomed place to store their cigarettes?

23 A. That might one piece of evidence, but we
24 have to look at whether or not he declared that he
25 had stopped smoking at that time. And also, for

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1 example, if he had gotten the cigarettes out of
2 the house instead of out of the usual place.

3 And if he had gotten the ashtrays out of
4 the house. And I have no evidence anywhere in any
5 of the records that he ever threw the cigarettes
6 out or that he took ashtrays out of the house. In
7 fact, I have something from Mrs. Williams'
8 testimony indicating that when she did take the
9 ashtrays out of the house, he bought new ashtrays.

10 Q. But in terms of whether he got rid of the
11 ashtrays or whether he got rid of the cigarettes
12 when he quit or not, don't you think it is a
13 little unfair to say that based upon the
14 deposition testimony that he never did when nobody
15 was ever asked if he ever threw the cigarettes or
16 the ashtrays away?

17 Isn't it a little unfair to say that he
18 didn't throw things away or didn't get rid of the
19 cigarettes when nobody was ever asked if that is
20 what happened?

21 A. Nobody ever asked him, that's for sure.

22 Q. Well, that's certain, isn't it?

23 A. Yes.

24 Q. Did the lawyers who prepared you to
25 testify today ever tell you that it was ever the

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1 plaintiff's position in case that Jesse Williams
2 was so addicted that he had no responsibility
3 whatsoever for his inability to quit?

4 A. No.

5 Q. Now, when you say on Exhibit 957 that
6 nicotine does not satisfy the practitioner's
7 definition of addiction, that's your view based
8 upon the 1964 Surgeon General's Report, right?

9 A. And my clinical experience.

10 Q. Well, isn't it true that after the 1964
11 Surgeon General's Report, quite a few things
12 happened in terms of the scientific community's
13 and the medical community's knowledge about how
14 nicotine works on people?

15 A. Yes.

16 Q. In fact, isn't it you true that after the
17 '64 report, there were numerous monographs
18 prepared in the 1970s by the National Institute on
19 Drug Abuse considering tobacco use as a form of
20 drug dependence?

21 A. I'm sorry, you're flipping the question.
22 What wasn't discovered after -- apropos of the
23 exhibit, since that what you asked me about,
24 apropos of the exhibit, after '64, subsequent
25 research never demonstrated nicotine to cause

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1 intoxication or euphoria.

2 They never demonstrated it to cause
3 tolerance in the fashion that typically was used
4 for that definition. They never demonstrated it
5 caused physical dependence equivalent to heroin,
6 amphetamines, cocaine, et cetera. And that all
7 subsequent research found variable and mild
8 withdrawal symptoms with some vague complaints of
9 discomfort.

10 That's what all of the research
11 demonstrated subsequently. How the term
12 addiction, the term addiction was defined
13 subsequent to '64, was changed, but the clinical
14 observations that I relied on to make the charts
15 that you wanted to question me about, didn't
16 change.

17 Q. Does that mean yes, that you recognize
18 that the National Institute on Drug Abuse
19 considered tobacco use as a form of drug
20 dependence in the '70s?

21 A. Yes, but it didn't change anything on
22 that chart.

23 Q. For my questions, I am going to have you
24 assume that you, the practitioner's definition,
25 did not change from the 1964 Surgeon General's

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1 Report.

2 A. Okay.

3 Q. And I'm going to run through with you
4 some of the things that did change and ask you
5 whether or not you recognize or acknowledge that
6 those things did change. I am not saying that you
7 changed, okay?

8 In 1980, did the American Psychiatric
9 Association and the DSM include tobacco dependence
10 as substance abuse disorder?

11 A. Yes.

12 Q. And the revised edition in 1987 of that
13 manual changed the word "tobacco withdrawal" to
14 "nicotine withdrawal," didn't they?

15 A. Correct.

16 Q. And in 1982, the director of the National
17 Institute on Drug Abuse testified to Congress that
18 it was the position of the NIDA, tobacco use could
19 lead to dependence and nicotine was a prototypic
20 dependence-producing drug?

21 A. I don't know about that testimony.

22 Q. What is a prototypic dependence-producing
23 drug?

24 A. I don't know.

25 Q. Well, let's break it down. Prototypic

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1 means, does it not, that it is a classic example,
2 a prototypical example of a dependence-producing
3 drug. That's what it means, doesn't it?

4 A. It might mean that. I would have to know
5 what his testimony was in context.

6 Q. Well, does that sound right based upon
7 the context in which I read it to you?

8 A. That might be one possible, reasonable
9 interpretation of what he said, but I would also
10 need to know what he said in context in order to
11 agree with you or disagree with you.

12 Q. Fair enough. Further, the U.S. Public
13 Health Service in 1983 on why people smoke
14 cigarettes, did you read that one?

15 A. '83?

16 Q. Yes. Why people smoke cigarettes?

17 A. No.

18 Q. Supported the position of the NIDA
19 regarding tobacco and nicotine.

20 MR. DUMAS: Your Honor, this sort of
21 sounds like hearsay to me.

22 THE COURT: What's the purpose for which
23 it's offered?

24 MR. THOMAS: Is he aware or is he not of
25 the changes which happened in the outside world

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1 that apparently occurred while his view stayed
2 the same since 1964.

3 THE COURT: You are offering these
4 references for the truth that these are changes
5 that did occur.

6 MR. THOMAS: I'm offering them for his
7 knowledge about the developments in the field in
8 which he claims expertise.

9 THE COURT: For the truth that these are
10 developments that happened. Your question
11 assumes that these, in fact, happened.

12 Your objection is hearsay?

13 MR. DUMAS: Yes, Your Honor, I'm sorry.

14 THE COURT: Objection sustained.

15 MR. THOMAS: Notice to him.

16 THE COURT: The objection is sustained.

17 BY MR. THOMAS:

18 Q. All right. In regard to your view
19 it's -- you said you didn't disagree, I guess,
20 but -- and this is Page 9, Counsel -- in terms of
21 the 1988 Surgeon General's Report, would it be
22 fair to say that in terms of the major
23 conclusions -- and the jury has seen this
24 before -- do you agree or disagree with the
25 conclusion, "Cigarettes and other forms of tobacco

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1 are addictive"?

2 A. Under his definition, I would agree.

3 Q. Do you agree with the assertion that
4 nicotine is the drug in tobacco that causes
5 addiction?

6 A. Under his definition, I would agree.

7 Q. And do you agree that the pharmacologic
8 and behavioral processes that determine tobacco
9 addiction are similar to those that determine
10 addiction to drugs such as heroin and cocaine?

11 A. I disagree. He doesn't know the
12 pharmacologic processes then or now.

13 Q. And isn't it true that what you told the
14 jury was really a little bit different in terms of
15 what the Surgeon General said, if I can find it.

16 A. I used the Dr. Benowitz definition.

17 THE COURT: Mr. Thomas?

18 MR. THOMAS: Yes, ma'am.

19 THE COURT: Over here at your desk
20 around --

21 MR. THOMAS: Oh, thank you.

22 THE COURT: -- the corner.

23 MR. THOMAS: Oh, all right. Here we go.

24 BY MR. THOMAS:

25 Q. We've got it here. The processes that

S. Raffle - X

1 determine tobacco addiction are similar to those
2 that determine addiction to those other drugs.

3 THE COURT REPORTER: I'm sorry. Would
4 you repeat that, please.

5 MR. THOMAS: Yeah.

6 BY MR. THOMAS:

7 Q. The processes that determine tobacco
8 addiction are similar to those that determine
9 addiction to drugs such as heroin and cocaine.
10 And then what you say is that addiction to tobacco
11 is similar to addiction to heroin or cocaine.

12 Well, the Surgeon General isn't saying
13 that people who are addicted to tobacco behave
14 similarly to junkies, cocaine and heroin junkies.
15 Isn't it right that what the Surgeon General is
16 saying is that the processes that lead to the
17 addiction are similar for these other potent drugs
18 that have profound pharmacological effects on the
19 human body?

20 A. Where I was disagreeing with the Surgeon
21 General is that the pharmacologic processes were
22 not understood in 1988, and still are not
23 understood. They had the dopamine hypothesis
24 then, but that's been rejected since then, so that
25 the pharmacological processes are not understood.

S. Raffle - X

1 If we want to look at behavioral
2 processes, then there are some things that in
3 terms of highly controlled, compulsive and used in
4 psychoactive effect that they do have in common,
5 but the pharmacologic processes still aren't
6 understood.

7 Q. Doctor, are you saying that -- you read
8 Dr. Benowitz's testimony?

9 A. I did.

10 Q. And you understand his position and
11 eminence within the field, do you not?

12 A. Yes.

13 Q. Are you saying that the findings that
14 nicotine is a potent psychoactive drug that
15 results in increased development of receptors in
16 the brains of animals and users of nicotine is
17 something that has been discredited by some
18 legitimate scientific organization?

19 A. I am talking about up regulation. Up
20 regulation is what it's called.

21 Q. I'm talking about what I just said.

22 A. Yes, that's called up regulation. And up
23 regulation does not occur with heroin, morphine,
24 amphetamines, cocaine, et cetera. It only occurs
25 with nicotine and caffeine. Down regulation

S. Raffle - X

1 occurs with morphine, heroin, amphetamines,
2 cocaine, barbiturates.

3 So the notion of increased receptors or
4 decreased receptors are opposites for drugs of
5 abuse, addiction, and for -- as compared to
6 nicotine and caffeine.

7 Q. Let's just say -- let's just say for
8 purposes of a hypothetical that you are right.
9 Are you aware of any scientific organization, any
10 health organization, or any of the other
11 associations that I described to you having
12 changed their view about the addictive or
13 dependence-producing properties of nicotine as a
14 result of the studies that you say reject the
15 increased receptor findings?

16 A. No. They haven't made their opinions on
17 that one way or another.

18 Q. And isn't it right, sir, that what you
19 told this jury this morning was that actually,
20 well, you know, you drink some milk to calm
21 yourself down at the end of the day, and it
22 results in an increase in dopamine production?

23 A. That's true.

24 Q. Well, how many people do you know who
25 have succumbed to the long-term effects of

S. Raffle - X

1 drinking milk at night before they go to bed?

2 A. In terms of the dopamine effect?

3 Q. No. In terms of any consequences from
4 their use of milk before they go to bed?

5 A. I am not going to split hairs. You could
6 argue heart disease, but put that aside. I think
7 that I was talking about psychoactive effects, and
8 milk has a psychoactive effect.

9 Q. Are you aware of any people who have a
10 dependency, a chemical dependency, on milk?

11 A. No. That was the whole idea -- that was
12 the whole point of my illustration.

13 Q. Now, isn't it correct that a part -- now,
14 I'm not -- I'm not saying that you -- you do or
15 don't believe this. I'm just trying to ask a
16 straight question and get a straight answer.

17 A. Of course.

18 Q. Isn't it right that some people believe
19 that a part of addictive or dependence-producing
20 behavior is that it results in denial by the
21 person who is using the drug?

22 A. Yes.

23 Q. Do you believe that denial is a part of
24 people's relationship to some types of drug usage
25 behavior?

S. Raffle - X

1 A. Yes, it may be.

2 Q. And you're aware, are you not, that --
3 are you a member of the American Medical
4 Association?

5 A. No.

6 Q. Are you aware that the American Medical
7 Association has conducted a study that has
8 demonstrated that smokers --

9 MR. DUMAS: Objection. Excuse me,
10 Counsel. I apologize.

11 This is hearsay, Your Honor.

12 THE COURT: Sustained.

13 MR. DUMAS: I apologize, Counsel.

14 BY MR. THOMAS:

15 Q. Are you aware of any studies that have
16 demonstrated that smokers, as opposed to
17 nonsmokers, have a different perception of the
18 risk associated with cancer or heart disease than
19 nonsmokers?

20 A. No.

21 Q. So that would be something that would
22 surprise you or you would expect to have occur?

23 A. I would need to look at the data. I just
24 haven't read anything about that.

25 Q. Have you ever looked as a part of your

S. Raffle - X

1 study of the use of nicotine at any polling, such
2 as the Gallop polls over the years, to see if
3 there was any difference between people who were
4 smokers and their perception of the risks
5 associated with smoking versus people who weren't
6 smokers?

7 A. No, I never looked at Gallup polls.

8 Q. So you're completely unaware of the
9 results?

10 A. Correct.

11 Q. Would it surprise you if I told you for
12 the purposes of a hypothetical question, that
13 smokers have a significantly lower association of
14 smoking with lung cancer than nonsmokers, in terms
15 of their beliefs about the danger that they're
16 encountering?

17 A. Would it surprise me? Well, I don't
18 think I would be surprised if it was that way or
19 the other way. Since I don't know, I wouldn't be
20 surprised one way or the other.

21 Q. And you just don't know one way or the
22 other?

23 A. No, I don't.

24 Q. I'm going to show you what's been marked
25 and admitted in this case as Exhibit 148, I think.

S. Raffle - X

1 It's called "Fact," and it's an ad that Philip
2 Morris -- see their little logo down there -- put
3 out in 1988 -- or 1994, I'm sorry.

4 A. Okay.

5 Q. Now, would you agree or disagree with
6 Philip Morris's statement, "Fact: Philip Morris
7 does not believe cigarette smoking is addictive"?

8 A. I don't know. All I know is what is
9 written there.

10 Q. Would you agree or disagree with the
11 assertion that cigarette smoking is not addictive?

12 A. Under my use of the term, I would -- I
13 would say that it may be -- well, no. Under my
14 definition of the term, or using the
15 practitioner's criteria, it would not be. Using
16 DSM-IV or the Surgeon General, it would be.

17 Q. So if Philip Morris was relying upon your
18 views about cigarette smoking and addiction, in
19 order to be truthful, they would have to say that
20 under one set of criteria, it is not addictive,
21 and under another set or another type of
22 definition, it can be addictive?

23 A. Let me read the rest of that if I may.

24 Q. Sure.

25 A. So what they said is -- the reason why

S. Raffle - X

1 they made the statement is they gave their
2 reasons, and I don't disagree with any of their
3 reasons. People can and do quit smoking all the
4 time. According to the 1988 Surgeon General's
5 report --

6 THE COURT REPORTER: Could you speak up,
7 sir. I'm having a little trouble hearing.

8 THE WITNESS: I'm sorry.

9 According the 1988 Surgeon General's
10 Report, there are more than 40 million former
11 smokers in the United States, and 90 percent
12 quit on their own without any help. Whether
13 that means it's addictive or not is another
14 matter.

15 BY MR. THOMAS:

16 Q. Isn't that consistent with your own views
17 about cigarette smoking and addiction?

18 A. It is part of the reason I have my
19 opinion, yes.

20 Q. It is part of the reason that what?

21 A. I have my opinions, but it's the absence
22 of intoxication, tolerance and withdrawal
23 described by me that is another part of it. Plus
24 the fact that people who are diagnosed with
25 addiction or nicotine dependence have the same

S. Raffle - X

1 quit rate as people who are not, and it doesn't
2 matter.

3 Q. All right. And almost finally, in terms
4 of the practitioner's definition of addiction,
5 under your definition of addiction, unless
6 nicotine causes intoxication, it can't qualify;
7 isn't that right?

8 A. Unless -- no. Yes, I guess that would be
9 true.

10 Q. That would be true, isn't it?

11 A. Yes.

12 Q. So the bottom line really is that since
13 nicotine doesn't cause intoxication, it can't
14 satisfy your definition, can it?

15 A. I never thought of that. That's correct,
16 although it could be -- I wouldn't disagree with
17 withdrawal and intoxication -- well, never mind,
18 enough said.

19 Q. Can you see how your views in regard to a
20 practitioner's view might be of use to a tobacco
21 company which is trying to defend a claim on
22 behalf of an allegedly addicted smoker?

23 MR. DUMAS: Objection, Your Honor,
24 argumentative.

25 THE COURT: The objection is sustained.

S. Raffle - X

1 BY MR. THOMAS:

2 Q. Would it be fair to say that your real
3 expertise, Doctor, is not in the area of addiction
4 research or writing?

5 A. I would agree that it is not in the area
6 of addiction research.

7 Q. It's really in the area of forensic
8 psychiatry, which is testifying about medical or
9 scientific matters that come to court?

10 A. That's one of my areas, but my other area
11 of expertise, unquestionably, is the treatment of
12 patients who have drug dependence due to chronic
13 pain.

14 Q. And you spend and have spent since, I
15 guess, about 1990, I think you said, about 25
16 percent of the time on your practice; isn't that
17 right?

18 A. Since '93.

19 Q. Since '93. You spent about how much of
20 your time on forensic work as opposed to clinical
21 work?

22 A. 75 percent since '93.

23 Q. 75 percent of your is court work, isn't
24 it?

25 A. No, not court work.

S. Raffle - X

1 Q. Forensic work?

2 A. Yes, but only -- court work is a very,
3 very, very, very small part of my practice.

4 Q. Eleven years since you first became
5 involved giving your views and being paid for
6 giving those views regarding tobacco usage, you've
7 never written a single article for any peer review
8 journal, so that somebody who is in the field, one
9 of your colleagues or more of your colleagues, can
10 review it, and put that out into the scientific
11 and medical literature world; isn't that correct?

12 A. Correct, not just on nicotine.

13 MR. THOMAS: Thank you, no further
14 questions.

15 THE COURT: Doctor -- do you want him
16 here?

17 MR. DUMAS: Just for one brief second.

18 THE COURT: Okay.

19 THE WITNESS: Okay.

20 MR. DUMAS: Then you can resume the
21 stand, Doctor.

22
23
24
25

S. Raffle - ReD

1 REDIRECT EXAMINATION
2

3 BY MR. DUMAS:

4 Q. Showing you Defendant's Exhibit 960 that
5 Mr. Thomas showed you and had you correct. Assume
6 the position please, Doctor. Thank you.

7 In order to make it technically correct,
8 as Mr. Thomas pointed out, since it's technically
9 possible for caffeine to result in intoxication,
10 in order to make this chart technically correct,
11 we need to check the caffeine intoxication column;
12 is that right?

13 A. Yes.

14 Q. Okay. Doctor, the fact that caffeine now
15 has five check marks -- check marks with regard to
16 those indicia of dependency, does that make
17 caffeine more addictive than nicotine?

18 A. No.

19 Q. Okay. The fact that caffeine now only
20 has one less check mark than heroin, does that
21 make heroin -- caffeine almost as addictive and
22 dangerous to folks as heroin?

23 A. No.

24 Q. You may resume the stand.

25 A. (The witness resumes the witness stand.)

S. Raffle - ReD

1 Q. Just a couple of quick questions, Doctor.
2 Number one, Counsel asked you about
3 who -- the World Health Organization. Did the
4 World Health Organization use the addiction
5 definition or the dependency definition for
6 nicotine prior to 1988?

7 A. They used the dependency definition.

8 Q. And when the Surgeon General came out
9 with the addiction model in 1988, did the World
10 Health Organization jump on the bandwagon and
11 change its definition?

12 A. No.

13 Q. What definition does the World Health
14 Organization use today with regard to this?

15 A. They still use the dependency definition,
16 very similar, if not identical, with DSM-IV.

17 Q. So would you agree, Doctor, that there
18 are significant worldwide even public health
19 organizations that do not use the addiction model?

20 A. Correct.

21 Q. Counsel asked you about how much time you
22 spend doing research and writing. Doctor, did you
23 make a professional decision to spend more time
24 working with patients than writing?

25 A. Yes.

S. Raffle - ReD

1 Q. The Cold Turkey, the movie, and the
2 memorandum that was produced following the release
3 of the movie, did the memorandum include a section
4 where there was an objective measurement of
5 baseline data to determine how irritable smokers
6 were before they quit, to determine how much loss
7 of energy they had before they quit, to determine
8 how many headaches they got before they quit, to
9 determine how often they experienced episodes of
10 constipation before they quit in order to compare
11 that baseline with the post-quitting symptoms?

12 A. No, they did not.

13 Q. And is the establishment of a baseline a
14 fundamental premise of any serious scientific
15 research?

16 A. Yes. That's what I was trying to say
17 before.

18 Q. And finally, Doctor, the nature, the type
19 and extent of symptoms identified in the movie
20 study, and how long they lasted, is any of that
21 consistent with your clinical experience with real
22 live people who quit smoking?

23 A. Some of the symptoms may occur for
24 varying lengths of time. My own real life
25 experience is that within two to three weeks all

S. Raffle - ReD

1 of the symptoms are gone except for the depression
2 component, and sometimes that will last up to 180
3 days, the dysphoria component.

4 Also the weight gain is a fairly regular
5 occurrence and persists as a rule, thereafter,
6 possibly because that was the person's normal
7 weight to begin with, and the smoking caused them
8 to lose their appetite and actually creating a new
9 lower baseline for their weight.

10 Q. Counsel asked you whether you used the
11 term "tolerance" was fair to this jury.

12 In referring you to the 1964 Surgeon
13 General's Report, did the Surgeon General in 1964
14 specifically discuss the fact that smokers take a
15 certain amount of time to reach a specified level
16 of smoking, many times over a number of years?

17 A. Yes, he did.

18 Q. And did the report specifically address
19 whether that phenomena meets the definition of
20 "drug tolerance"?

21 A. It explicitly discussed it and said it
22 did not for the reasons I discussed earlier.

23 Q. Doctor, Counsel asked you about
24 perception by smokers of the health risks
25 associated with smoking.

S. Raffle - ReD

1 Over 25 years of practice, Doctor, has
2 any one of your patients expressed surprise when
3 you discussed with them that there was a potential
4 of serious health consequences as a result of
5 cigarette smoking?

6 A. No, they haven't. They've all known it
7 was risky.

8 Q. Finally, Doctor, Counsel asked you about
9 the medical records involving Jesse Williams, and
10 he pointed out to you quite correctly that the
11 medical records document that in 1989,
12 Mr. Williams was prescribed Nicorette gum.

13 How many times, Doctor, or even before
14 1989, do the medical records document that
15 Mr. Williams was prescribed any kind of smoking --
16 smoking cessation assistance?

17 A. Medical records indicate none.

18 Q. Prior to 1989, how many times do the
19 medical records indicate that Mr. Williams asked
20 for medical assistance of any type, including
21 smoking cessation programs to help him quit
22 smoking?

23 A. None.

24 Q. Between 1989 to 1996, when his cancer was
25 diagnosed, how many times do the medical records

S. Raffle - ReD

1 indicate that Mr. Williams went to his physicians
2 and said something to the effect, "Doctor, I've
3 tried to quit a couple of times and I can't make
4 it. I need some help. What do you recommend?"

5 A. The records indicate that he never made
6 such an inquiry and that nothing was prescribed.

7 MR. DUMAS: Thank you. That's all I
8 have.

9 THE COURT: Thank you, Doctor. You may
10 step down.

11 Jurors, we have another defense witness,
12 and we're going to be breaking around 4 o'clock.
13 My question to you is can you go another 15
14 minutes or so before we take a short afternoon
15 break, or does anybody need a recess right now?

16 Okay. Call your next witness.

17 MR. DUMAS: Thank you, Your Honor. We
18 call Dr. Ron Turco to the stand.

19 THE CLERK: Doctor, please remain
20 standing and raise your right hand.

21
22
23
24
25

R. Turco - D

1 RONALD TURCO
2 Was thereupon called as a witness on behalf of the
3 Defendant and, having been first duly sworn, was
4 examined and testified as follows:

5
6 THE CLERK: Please be seated.
7 For the record, state your full name,
8 spelling both first and last names.

9 THE WITNESS: It's Ronald Turco,
10 R-o-n-a-l-d, T-u-r-c-o.

11 MR. DUMAS: Thank you.

12
13 DIRECT EXAMINATION

14
15 BY MR. DUMAS:

16 Q. Dr. Turco, it is almost 3 o'clock. The
17 Court has just advised we're going to break at
18 4:00. With some indulgence, I am going to attempt
19 to move this along quickly, and perhaps we can get
20 to the heart of it by briefly summarizing who you
21 are.

22 You are a psychiatrist that practices
23 here in Portland?

24 A. Yes, a Doctor of Medicine, and I practice
25 psychiatry.

R. Turco - D

1 Q. How long have you practiced psychiatry,
2 Doctor?

3 A. Since 1970.

4 Q. And would you give us a thumbnail sketch
5 of the types of patients that you have treated
6 over 25 years?

7 A. Well, I began treating patients with
8 general emotional disorders, and then I
9 sub-specialized in treating patients who lost
10 children and that was a substantial part of my
11 practice for many years; usually children, through
12 accidents or murder or what have you.

13 And I have also worked fairly intensively
14 with police officers throughout the years, and
15 probably evaluated or treated 10 or 15,000 police
16 officers in various departments. I have
17 sub-specialized in some cross-cultural work,
18 working with Native Americans and also
19 Afro-Americans.

20 And I eventually, as time went on, began
21 to work with injured workers, because I am very
22 interested in general medicine. And so the
23 referrals that I would obtain would be people with
24 amputations and physical injuries.

25 And that sort of led me into this

R. Turco - D

1 forensic arena of testifying and going to
2 factories. I like to spend time in factories, and
3 steel mills and that sort of thing. And that
4 essentially developed into a primary interest of
5 mine, so over the years that is kind of what has
6 occurred.

7 Q. And why don't you again give us a brief
8 summary of your clinical experience as it relates
9 to substance abuse and substance addiction and
10 dependency, and all those things that we have been
11 talking about today?

12 A. Well, I have had the general training, of
13 course, that all psychiatrists have and --

14 Q. We'll go through that briefly.

15 A. I went into the military service in 1970,
16 and I was assigned to develop a program for the
17 active duty Viet Nam veterans. And I did that and
18 wrote an Air Force manual on substance dependence
19 around '71 or so. And I worked on a unit and
20 pretty much worked on detoxification and addiction
21 problems.

22 And then when I was discharged, I spent a
23 year at a Mennonite hospital working with
24 substance dependent people, as well as people with
25 other psychiatric disorder.

R. Turco - D

1 And then in about 1973 or so when I began
2 private practice in Portland, I was -- I became
3 the director of a psychiatric hospital. The
4 primary emphasis was addictionology and addiction
5 medicine. I am not an addictionologist. I am a
6 psychiatrist.

7 And so I have had that experience. And
8 then over the years I worked with impaired
9 physicians. At one time, I was on the Impaired
10 Physicians Committee at Good Samaritan Hospital.
11 I helped to develop their program, impaired being
12 associated with substance dependence and abuse.

13 And I have also been an ongoing
14 consultant with the dental board here in Oregon,
15 basically treating dentists who are addicted and
16 formulating programs and actively treating them.

17 Q. How and when did you become involved in
18 this case?

19 A. In September, I believe September of
20 1998, you telephoned my office.

21 Q. And did you agree to review the records
22 in this case?

23 A. No.

24 Q. What do you mean?

25 A. As I know, I did not was to become

R. Turco - D

1 involved in a defense case involving tobacco
2 companies.

3 Q. Initially you did not want to become
4 involved?

5 A. That's correct.

6 Q. Why is that?

7 A. There are several reasons. My father
8 died of cancer possibly related to smoking. I've
9 had family members with illnesses possibly related
10 to risk factors. As a physician, I don't approve
11 of smoking, I don't think it is a healthy habit,
12 and I just couldn't see myself involved in this
13 type of situation.

14 Q. Did you change your mind?

15 A. I did change my mind with regard to the
16 particulars and the issues. I haven't changed my
17 mind about the idea of smoking.

18 Q. That's what I meant. Why did you agree
19 to become involved in the case and review the
20 records?

21 A. Well, first of all, you and other
22 individuals, basically indicated that I was free
23 to express my opinions, and my condemnation of the
24 smoking habit, and there were no restraints on
25 anything that I wanted to say.

R. Turco - D

1 And also that when I looked at the
2 situation, it become a question of whether an
3 individual has a personal responsibility or free
4 choice, and I feel strongly about some of those
5 issues.

6 Q. And are you charging an hourly rate for
7 your services, both in reviewing the records and
8 testifying?

9 A. Yes.

10 Q. Okay. What is that rate?

11 A. I never discussed money with any of the
12 attorneys, but that rate would be about \$250 an
13 hour.

14 Q. Okay. Given your feelings about smoking,
15 Doctor, have you had over the last 25-plus years,
16 discussions with your psychiatric patients about
17 the health risks associated with smoking?

18 A. Yes.

19 Q. What percentage of folks here in Portland
20 that you've talked to, your patients, about the
21 health risks of smoking have expressed shock or
22 surprise or ignorance of the linkage, the health
23 risk of health -- let me rephrase the question.

24 What percentage of your patients
25 expressed surprise that there was any relationship

R. Turco - D

1 between smoking and health risk?

2 A. I can't think of a one.

3 Q. Doctor, would you briefly summarize for
4 us the records that you reviewed specific to this
5 case before coming into court.

6 A. Yes. I reviewed a great many
7 depositions, Mrs. Williams, family members,
8 Mr. Williams' children. I reviewed in detail all
9 of Mr. Williams' medical records. I reviewed
10 trial transcripts of Mrs. Williams, and also
11 Dr. Benowitz and Dr. Kern, and a few related
12 materials. They included personnel records of
13 Mr. Williams.

14 Q. Doctor, I would like to summarize your
15 educational background briefly. Would it be fair
16 to say that you stay current with the psychiatric
17 literature and have over the last 20-plus years?

18 A. Yes.

19 Q. And you're licensed to what medicine in
20 what states?

21 A. Actively licensed in Oregon.

22 Q. Would you briefly summarize your
23 education, please, sir, starting with your
24 undergraduate degree?

25 A. I attended the Pennsylvania State

R. Turco - D

1 University, and studied chemistry and physics,
2 completing the program in 1962. And then I went
3 to Jefferson Medical College in Philadelphia. I
4 completed general medical studies in 1966. I took
5 a year of surgery and rotated medicine in a small,
6 but very good hospital outside of Philadelphia. I
7 completed that late '67.

8 I went on to the University of North
9 Carolina, studied psychiatry for one year, and
10 then transferred to the Oregon Health Sciences
11 University and completed a program in psychiatry
12 in 1970.

13 Q. Are you board certified, Doctor?

14 A. Yes, I am board certified by the American
15 Board of Psychiatry and Neurology and when I took
16 the boards, it was necessary to take them in
17 neurology as well, but the designation is in
18 psychiatry.

19 Q. You have been board certified since when?

20 A. 1973.

21 Q. Are you also a diplomat of the National
22 Board of Medical Examiners?

23 A. Yes.

24 Q. Is that a position that not all
25 psychiatrists, even board certified psychiatrist

R. Turco - D

1 have?

2 A. That's a position that not all physicians
3 have. It basically implies -- well, the medical
4 school that I went to insisted that physicians
5 take necessary examinations which occurred over
6 several days. I went to a hand's on medical
7 school that emphasized medical clinical training,
8 and what the board allows is reciprocity and
9 licenses in both states.

10 Q. Doctor, I understand that you served
11 active duty as well as perhaps some reserve work,
12 I can't recall, in the Air Force?

13 A. Yes. I have 11 years reserve work in the
14 U.S. Air Force, and I was on active duty for about
15 two years, five months.

16 Q. Why don't you briefly summarize for us
17 what you did in the Air Force as it relates to
18 your profession of psychiatry?

19 A. I did a whole variety of things. I'm a
20 volunteer type, so I volunteer for everything that
21 I can, and I initially worked on the substance
22 dependency, and then I worked in general medicine
23 at a base in the Arctic under the ice. I lived
24 underground for long periods of time. I lived out
25 in the Arctic on the Aleutian chain.

R. Turco - D

1 I took care of people who were burned,
2 crushed, and what have you, triaged them, flew
3 them out when I had to. And then I worked for Air
4 Force intelligence for a period of time, and was
5 interested especially in the development of
6 psychological profiling, and I was actively
7 trained, to some extent, to do psychological
8 profiles of political figures and generals and so
9 on.

10 Q. What is a psychological profile?

11 A. A psychological profile is simply a
12 composite of information that you collect about a
13 person, and which you try to predict what that
14 person might do.

15 For example, when President Kennedy met
16 with Krushchev for the famous summit, Kennedy had
17 been given a briefing on Krushchev's personality
18 characteristics, his alcohol consumption, his
19 temper, what he would do in response to certain
20 questions and so on. And that is actively done
21 and has been done for many years.

22 It is an attempt to predict behavior and
23 an attempt to understand behavior. One of the
24 more modern original profiles was that of Adolf
25 Hitler, which was a profile that was done by

1 Dr. Langer, and that was kept top secret until
2 1973.

3 MR. THOMAS: Your Honor, I have a matter
4 for the Court.

5 THE COURT: We can take the afternoon
6 recess and I can take this up, but, Jurors, I'll
7 meet you at the jury room door in the event that
8 Mr. Rice isn't available to open it. You step
9 out.

10 (Pause in proceedings.)
11 (Whereupon, the following
12 proceedings were held in
13 open court, out of the
14 presence of the jury:)

15 THE COURT: All right.

16 MR. THOMAS: Your Honor, I see emerging a
17 post-death psychological evaluation of Jesse
18 Williams emerging here, which is (A) duplicative
19 to what has previously been offered by
20 Dr. Raffle; (B) I believe it is of questionable
21 scientific basis; (C) even if there is some
22 scientific basis for it, I believe that it
23 invades the province of the jury on the question
24 of personal responsibility.

25 And finally, under a 403 analysis is

1 something that opens many more doors than should
2 be opened. And if we are to the point in our
3 Court system where we are going to do post-death
4 MMPIs of people, it is going to create a need
5 for response which is going to, I believe, be
6 way out on collateral matters.

7 THE COURT: Mr. Dumas, are you going
8 there?

9 MR. DUMAS: I guess I am, Your Honor. I
10 certainly do intend on having the doctor
11 summarize for the jury his analysis of
12 personality characteristics and traits of
13 Mr. Williams as indicated based upon the
14 employment records and the medical records and
15 depositions of family members.

16 THE COURT: Let me be sure, Mr. Thomas,
17 that I understand your four grounds.

18 One is that this is duplicative of
19 Dr. Raffle's testimony, and at least as to what
20 Mr. Dumas has just now talked about, it seems
21 not to be. It seems to be more specific. Your
22 second ground is that this lacks scientific
23 foundation, so I convert that objection into
24 your request for a 104 hearing on foundation.
25 Is that what you're asking me?

1 MR. THOMAS: Yes.

2 THE COURT: And as to invading the
3 province of the jury or doing a 403 balancing
4 act, you know, I can't do that until I know what
5 the witness is going to say.

6 I need to give the reporter a brief
7 recess, and as soon as she is ready, we'll come
8 back and you can lay a foundation on the
9 scientific basis or the psychiatric basis for
10 providing a profile, based upon the kinds of
11 records that the witness has reviewed and in the
12 absence of an MMPI or any kind of personal
13 contact, and then we'll see where that leads.

14 (Recess taken.)

15 (Whereupon, the following
16 proceedings were held in
17 open court, out of the
18 presence of the jury:)

19 THE COURT: Mr. Dumas, you may inquire.

20 MR. DUMAS: Thank you, Your Honor.

21
22
23
24
25

R. Turco - O/P

OFFER OF PROOF

BY MR. DUMAS:

Q. Doctor, please, in be a brief overview fashion, would you explain to the Court how the role of psychological profiling of psychiatry, generally and specifically, the role and the use of psychological profiling in forensic psychiatry?

A. Well, to begin with, psychological profiling has been used for hundreds of years, and Freud initiated substantial studies in psychological profiling, and I've alluded to some of the political implications and there use politically.

All governments use psychological profiles. They use psychiatrists and psychologists to generate profiles upon which some very basic decisions are made. For example, President Reagan has videotapes of psychological profiles that were done for him when he met with Gorbachev, and so on.

From a practical perspective, I think all doctors look at medical records. All doctors draw conclusions from medical records, particularly psychiatrists, and I think in forensic psychiatry,

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1 this is very much the case.

2 I have testified in testamentary capacity
3 cases. I've looked at videos of people who have
4 long since have left this earth. I have also read
5 their medical records, with or without videos, and
6 I've drawn conclusions that I think are reasonably
7 probable about the individual and their particular
8 intent, so I think it's done on that basis.

9 I would also point out to you, there are
10 some textbooks, most of them are of a police
11 nature, but there are textbooks that specifically
12 deal with profiling. And also I, for example, was
13 involved with a murder case in Vancouver in which
14 the judge, on the basis of my psychological
15 profile, issued an affidavit for a search warrant.
16 I think it was unprecedented in Washington state.

17 So it is -- it is not a hard science,
18 like chemistry or physics, but it is an evolving
19 science and I think it's a reasonable one. It
20 doesn't mean that it's absolutely perfect, and I
21 think what we do go is usually drawn on factual --
22 specific factual information, and it's not
23 conjecture, it's specific.

24 Q. Is psychological profiling generally
25 accepted by most psychiatrists in the community?

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1 A. Well, I can't speak for most
2 psychiatrists in the community. I know that my
3 colleagues always ask me to speak publicly and at
4 their meetings. They ask me to teach some of this
5 to the students.

6 Certainly, the police agencies absolutely
7 love it, because it does help them substantially
8 to narrow down investigative cases. I've never
9 had a problem with any of my colleagues with
10 regard to profiles. I've never heard anybody
11 pooh-pooh it.

12 Q. What about the acceptance of
13 psychological profiling among the forensics
14 psychiatric community?

15 A. Well, I think that's without a doubt
16 quite well accepted.

17 MR. DUMAS: Thank you.

18 That's all I have, Your Honor.

19 THE COURT: I would like to know what the
20 general conclusions are that the witness would
21 testify to because that would go into my
22 evaluating all of Mr. Thomas' objections.

23 BY MR. DUMAS:

24 Q. In a thumbnail sketch fashion what are
25 your general conclusions about Mr. Williams as

R. Turco - O/P

1 they relate to the issues in this case, what kind
2 of person he was.

3 A. My general conclusions are that
4 Mr. Williams was a wonderful, decent human being,
5 very family oriented. He was intelligent. He was
6 a hard worker. He was a man about himself. He
7 was a man of decision-making. He was independent.
8 He did what he thought was best. He had
9 independent thoughts. He was well read.

10 And basically he had a free choice to
11 smoke or not smoke. He is no different than
12 anyone else who has discontinued smoking.

13 MR. DUMAS: Unless the Court has other
14 specific questions, that's all I have.

15 THE COURT: Any questions in aid of
16 objection?

17 MR. THOMAS: Yes.

18

19 OFFER OF PROOF

20

21 BY MR. THOMAS:

22 Q. You talked about how your work had
23 resulted in the issuance of an affidavit in
24 another case in another state, and that that was
25 the first time that forensic profiling had been

R. Turco - O/P

1 used?

2 A. No, only --

3 Q. I'm sorry.

4 A. I'm sorry.

5 Q. In such a way. I thought that's what you
6 said.

7 A. No, absolutely not. It was a precedent
8 in Washington state only.

9 Q. That's what I was trying to say.

10 A. In that state.

11 Q. Yeah.

12 A. Yeah, only, but it had been used for
13 similar purposes in other states.

14 Q. And in regard to testifying in any court
15 in Washington in a noncriminal matter in front of
16 a jury, as opposed to a probation violation or a
17 sentencing hearing or something of that nature in
18 a criminal case, have you ever presented in
19 Washington state your psychological profiling?

20 A. Yes, I have, in pension board hearings.

21 THE COURT REPORTER: I'm sorry -- in what
22 hearings?

23 THE WITNESS: Pension board, police and
24 fire pensions.

25

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1 BY MR. THOMAS:

2 Q. I'm sorry, my question was maybe not
3 clear.

4 In Washington state you've never
5 testified in front of a jury about this
6 psychological profiling in regard to somebody for
7 whom you haven't had a one-on-one interview,
8 correct?

9 A. Well, I did in the case that I mentioned
10 eventually. I was called into court to present
11 that material.

12 Q. In the jury trial?

13 A. Yes.

14 Q. And was that a criminal case?

15 A. Yes.

16 Q. Have you ever in a civil case presented
17 psychological profiling in the state of Washington
18 in front of a jury?

19 A. Not where I called it that, no.

20 Q. In regard to what is or isn't helpful to
21 the law enforcement community, the law enforcement
22 community finds it very helpful to use lie
23 detector tests, don't they?

24 A. Not usually, no.

25 Q. Well, they use them in probation

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1 violation hearings, don't they?

2 A. Well, that may be, but I don't know who
3 asks for those. I know the police don't -- don't
4 care for it very much. The State Police utilizes
5 it to some extent, but it is taken with a grain of
6 salt.

7 Q. In fact, they have polygraphers on staff?

8 A. The State Police does.

9 Q. And that is not something that is used in
10 court, is it?

11 A. No.

12 Q. And in this case, you have, of course,
13 never examined Jesse Williams?

14 A. Correct.

15 Q. And you've never seen an MMPI or a
16 psychiatric examination of him?

17 A. That's correct.

18 Q. Have you testified in Oregon in a civil
19 case in this courthouse in front of a jury in a
20 noncriminal case using your psychological profile
21 techniques?

22 A. I testified in a noncriminal case
23 involving an attorney, and that was in this
24 courthouse, but most of that testimony was given
25 by deposition, and then I appeared in person and

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1 gave some further information.

2 Q. And was that based upon a situation where
3 the attorney was examined by you?

4 A. No. The attorney refused the
5 examination, and I was asked to develop the
6 profile and go in on the records.

7 Q. And the profile -- and the nature of the
8 proceeding was what?

9 A. He was filing for permanent disability,
10 claimed that he had an anxiety reaction when he
11 came into court.

12 Q. And was that a jury trial claim?

13 A. Yes, it was a Federal case. I'm sorry,
14 it was a Federal case. It wasn't in this
15 courtroom.

16 Q. So it was a suit on an insurance
17 contract?

18 A. Yes.

19 Q. Was there any MMPI, or any medical,
20 psychological or psychiatric medical records that
21 you reviewed?

22 A. In that case, there were, by other
23 treating psychiatrists.

24 Q. And there are no other treating
25 psychiatrists or psychologists or medical records

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1 in this case for you to review, are there?

2 A. No.

3 Q. In fact, your examination is not based
4 upon any treatment of Jesse Williams by any mental
5 health professional at all, correct?

6 A. That's correct.

7 Q. The opinion that you are going to render
8 is one relating to free choice; in other words,
9 that Jesse Williams was no different than any
10 other person in terms of making a free choice,
11 correct?

12 A. Correct.

13 Q. A person having or not having a free
14 choice is not a diagnostic condition that's found,
15 for example, in the DSM-IV, is it?

16 A. No. Unless you consider the absence of
17 psychopathology as being a relevant factor.

18 Q. Have you ever testified in any other
19 court in front of a jury in a noncriminal case
20 anywhere about whether or not free choice was
21 present in this particular person's psychological
22 profile or not, where you haven't had a
23 psychological-medical history or an opportunity to
24 exam the person yourself?

25 A. No.

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1 Q. So this would be the first time?

2 A. As far as I can tell, I think it would
3 be. I have done -- I have testified in
4 depositions, but not before a jury in court.

5 MR. THOMAS: Excuse me just a moment.

6 (Discussion off the record
7 between Counsel.)

8 MR. THOMAS: I guess most of the rest of
9 what I have is argument.

10 THE COURT: Any other questions?

11 MR. DUMAS: I do have just one or two
12 quick follow-up questions.

13 THE COURT: Go ahead.

14

15 OFFER OF PROOF

16

17 BY MR. DUMAS:

18 Q. Doctor, has the techniques and the
19 process of psychological profiling, has that been
20 utilized in psychiatric peer review journals and
21 been recognized as a technique within the
22 psychiatric community?

23 A. I don't know.

24 Q. So you can't cite to us peer-reviewed
25 articles in which the technique has been utilized

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1 and subjected to peer review?

2 A. That specifically say, "This is a
3 psychological profile"?

4 Q. Yes, sir. A psychological profile, as I
5 understand it, means a psychological workup, if
6 you will, of an individual who had previously not
7 been evaluated in person by another psychiatrist
8 or psychologist.

9 A. Well, there are all sorts of information
10 in the journals about that type of thing. They
11 just don't call it "psychological profiles."

12 Q. What do they call it?

13 A. Oh, case presentation, grand rounds
14 presentation, clinical study, what have you.
15 That's always done, and it's usually done
16 anonymously. So in other words, you don't know
17 who the person is. You're basically taking the
18 data available, and then the reviewer or the
19 writer draws some conclusions.

20 MR. DUMAS: Thank you.

21 THE COURT: Argument on the objection?

22 MR. THOMAS: Well, we have had testimony,
23 from Dr. Raffle that Jesse Williams was
24 unaffected by anything that made it so that the
25 decision to quit or to smoke was anything other

1 than his personal choice. And he used his
2 analysis on all of these charts, because of the
3 nature of the drug.

4 And he also used his analysis of the
5 testimony about who Jesse Williams was, and his
6 family background, how many people in his family
7 had quit and not quit, what he had said, how he
8 behaved, how his wife had behaved, and how he
9 had known things relative to the doctors, other
10 clinical patients, so we do have, I believe,
11 that in the record.

12 The question of free choice is one that
13 is -- or and/or personal responsibility, is one
14 that is peculiarly within the jury's province in
15 this case. And what we have here is a
16 postmortem MMPI being performed with no history
17 of medical or psychological basis by Dr. Turco
18 and really, he said it himself, that the
19 conclusion is going to be to the jury that Jesse
20 Williams had a free choice, which is one of the
21 main questions in this case.

22 And when the Court considers the novelty
23 of the concept, the degree of non-acceptance, or
24 at least the out-of-the-mainstream character of
25 this type of analysis, the lack of acceptance of

1 it in the peer reviewed literature and in the
2 scientific literature, the invasion of the
3 province of the jury, the speculative,
4 necessarily speculative nature of coming in
5 where there is absolutely no psychological or
6 other psychiatric medical record, and conducting
7 a postmortem of a party, and the likelihood that
8 it is going to be viewed as would lie detector
9 testimony or truth serum testimony, with
10 considerable weight by the jury.

11 Coupled with the extremely difficult
12 chore that somebody would have in
13 cross-examining on it, and the opening of the
14 matter to -- of response based upon a similar
15 dearth of data --

16 THE COURT REPORTER: I'm sorry, a similar
17 what?

18 MR. THOMAS: Dearth -- lack of data.

19 THE COURT: D-e-a-r-t-h. I'm just trying
20 to be helpful here, not as in Vader.

21 THE COURT REPORTER: Thank you.

22 MR. THOMAS: -- all combined, I believe,
23 to put this over the 403 hurdle, and the
24 plaintiff's request that this Court disallow
25 this testimony.

1 THE COURT: Mr. Dumas.

2 MR. DUMAS: You know, Your Honor, you
3 look at this, bottom line, I am not sure this is
4 much, if any, different, than what plaintiff did
5 with Dr. Benowitz. Dr. Benowitz got on the
6 stand. He never met Jesse Williams. He never
7 evaluated. There was no psychological
8 evaluation for Dr. Benowitz to look at.

9 What did Dr. Benowitz do? He testified
10 in his opinion to a reasonable medical
11 probability Jesse Williams was addicted to --
12 which is a psychological, psychiatric condition
13 to the cigarettes, to nicotine, based on all
14 sorts of things in the medical record, in the
15 deposition record, facts that he pulled out,
16 that he distilled down, and said, "These are
17 pertinent, relevant important pieces of data
18 that I, as a physician, can rely upon to say
19 this man, who I never met, who was never
20 subjected to a psychiatric evaluation, was, in
21 fact, addicted," which is a psychiatric disease.

22 So I, you know, we're kind of putting a
23 New Age label on it, "psychological profile," I
24 am not really sure it is any different than what
25 Dr. Benowitz has done, or what a lot of

1 physicians do day in and day out in this
2 courthouse. They may not call it a
3 psychological profile.

4 Second, Counsel's argument that this
5 invades the province of the jury, I find
6 unpersuasive. Experts testify all the time as
7 to their opinion of ultimate fact. The jury
8 will be instructed that they can take it for
9 what it's worth or they can disregard it if they
10 don't think it is valid.

11 Third, the Doctor was testifying that it
12 is routine and customary for forensic
13 psychiatrists to do exactly what he is doing;
14 that they routinely look at medical records and
15 depositions and other kinds of testimony of
16 people they have not met and render opinions
17 about the psychological condition, the absence
18 or the presence of psychological -- psychiatric
19 pathology in some -- in a person.

20 And the fact that this physician, who is
21 just one of many forensic psychologists and
22 psychiatrists in this community, could not come
23 up with, by the seat of his pants, an example of
24 where he's testified in this courthouse in front
25 of a jury, the fact remains that he has

1 testified a lot, and he's indicated to -- in
2 other bodies regarding psychiatric profiles, and
3 so I don't find that persuasive.

4 And Your Honor, you have got to look at
5 O'Key, and I think that's what the Court's got
6 to -- got to look at here, the four criteria
7 that is set out in O'Key, which, of course, is
8 an acceptance of the Daubert analogy: Can the
9 technique be tested?

10 The Doctor said it's sort of not, you
11 know, it's not mathematical. It's not like
12 biochemistry, but then, again, not much in
13 psychiatry can be objectively tested.

14 Second, has the concept been subjected to
15 peer review? He candidly acknowledged, well,
16 maybe not what I can think of in terms of being
17 called a psychological profile, but there's
18 articles in the psychiatric literature all the
19 time in which psychiatrists are opining as to
20 the psychiatric pathology of someone they've
21 never met based upon medical records and
22 interviews and statements.

23 Third, the potential rate of error in the
24 operational standards. We don't have much to go
25 on there.

1 And fourth, the degree of acceptance in
2 the relevant scientific community. And he,
3 again, candidly testified, "I don't know what it
4 is, what the acceptance rate is in the broader
5 psychiatric community, but it's certainly
6 accepted in the forensic psychiatric community."

7 That's all I have.

8 MR. THOMAS: I just have a couple of
9 things to add, Judge.

10 One is -- actually, one is if Benowitz
11 needed to be met in his opinion, he was
12 certainly met and rebutted by Dr. Raffle. And
13 his was an opinion, not of a psychological
14 nature, but of a physiological nature, based
15 upon the pharmacological properties of addiction
16 and the criteria for addiction that are known
17 and well recognized within his discipline.

18 And Dr. Raffle rebutted with his
19 practitioner's analysis, so that point has been
20 made and prepared.

21 Second, if we are to the point where,
22 aside from the O'Key analysis, put on 403
23 analysis, we're in the courts, what we're going
24 to do is allow mental health or other
25 professionals to come in and provide evidence

1 about a key non-medical, non-psychological area,
2 such as free choice or individual choice, then
3 we're going to be seeing evidence in car
4 accident cases about how people's makeup --

5 THE COURT: Well, let's just leave it to
6 this case, okay? I'm not worried about tomorrow
7 or the next day. I am worried about this
8 record, and you're threatening me with
9 psychological profiles in car accident cases
10 isn't really helpful argument.

11 MR. THOMAS: All right.

12 THE COURT: Okay. Anything else?

13 MR. THOMAS: Well, under O'Key I don't --
14 I think my questions did not go to the first
15 criteria very much, which was the theory can be
16 tested. And this is a theory that is
17 practically impossible to test.

18 The Doctor was honest, forthright and,
19 really, this is something that maybe someday it
20 will rise to the level of sufficient scientific
21 acceptance for admissibility, but it certainly
22 does not sound like it is there yet.

23 THE COURT: Remind me whether there was
24 objection to Dr. Benowitz's offering opinions
25 about whether Mr. Williams was addicted.

1 MR. THOMAS: There was not.

2 MR. DUMAS: There was not, I concur.

3 THE COURT: My ruling is going to go down
4 two paths. First, the witness is a qualified
5 psychiatrist. He is competent to offer opinions
6 in his field by training, education and
7 experience.

8 The real risk of error here has to do
9 with the label "psychological profiling,"
10 because the label itself can be misunderstood to
11 bolster the actual underlying opinion.
12 Dr. Turco himself said that what is referred to
13 in the literature as a "case presentation," or
14 was it "grand rounds"?

15 THE WITNESS: Yes.

16 THE COURT: Grand round studies, and so
17 forth, are, in effect, a form of profiling; but
18 that's not what it's called. In the literature
19 it is called "case presentation," and it's
20 called "grand round studies."

21 Profiling, as a shorthand term, has
22 inherent in it lots of risks of misunderstanding
23 and mis-evaluation by a jury. If Dr. Turco has
24 an opinion about whether Mr. Williams was
25 addicted or not based upon his review of the

1 medical records, he can offer that opinion, just
2 like other physicians have offered opinions
3 about whether Mr. Williams was addicted.

4 But calling it profiling, I think, risks
5 error. And maybe you want to look at this as my
6 being overly careful to avoid errors in the
7 record, but I don't want to run that risk.
8 First of all, and this is with all respect to
9 this witness and his sterling qualifications,
10 the issue of profiling doesn't meet the O'Key
11 test in terms just summarized by Mr. Dumas.

12 If I let it in as a profile opinion, and
13 the defendant prevails, we've got plain error on
14 the face of the record. Dumas -- Mr. Dumas has
15 as much as conceded that the foundation hasn't
16 been laid. Maybe he won't say that, but I will,
17 in terms of my 104 responsibilities, and there
18 is no point in planting error in the record,
19 there just isn't.

20 Secondly, apart from what might be seen
21 as my protecting the defense, and, please,
22 that's not really what I am trying to do. I am
23 trying to protect the integrity of this record
24 to see to it that whatever result we get is one
25 that will stand.

1 I have no authority in the face of an
2 O'Key foundation lacking here, to allow
3 testimony characterized as psychological
4 profiling because of the risks of
5 misunderstanding that the jury might apply to
6 it, and because it doesn't meet all of those
7 gatekeeper criteria I'm required to find.

8 I have a different concern, though, and
9 that is whether even assuming Dr. Turco has an
10 opinion about whether Mr. Williams was addicted
11 or not, or whether he could quit smoking if he
12 chose or not, without calling it profiling, the
13 extent to which that is new evidence and not
14 cumulative, I don't think anyone is going to
15 contest, first of all, that Mr. Williams was a
16 wonderful, decent family man; that he was
17 intelligent, hard working, independent, well
18 read.

19 That has all been brought out a number of
20 times on cross-examination of the plaintiff's
21 witnesses, by the defense, and so forth. So
22 what I am really focusing on is the extent to
23 which we need -- there needs to be more evidence
24 about whether he is addicted or not from the
25 defense perspective.

1 There was, in fact, a psychiatrist on the
2 stand all day today who talked about lots of
3 things, but also included, an opinion that he
4 could have stopped any time he chose. And how
5 is this materially different from that,
6 Mr. Dumas?

7 MR. DUMAS: That is a legitimate
8 question, Your Honor.

9 THE COURT: Thanks, I thought so.

10 MR. DUMAS: That's probably why you asked
11 it.

12 You know, I guess I would probably have
13 to concede a little bit that there is a smack of
14 -- smattering here of cumulative testimony. By
15 the way, just so Your Honor's understanding is
16 crystal clear, I don't anticipate to ask this
17 witness his opinion of whether Jesse Williams
18 was addicted, or whether Jesse Williams was
19 substance dependent, or the difference between
20 the two, or the WHO organization standards, or
21 the Surgeon General's, or DSM, okay? That would
22 be background stuff that would be highly
23 cumulative.

24 However, I do intend on asking this
25 witness' opinion to a reasonable psychiatric

1 probability whether he believes Jesse Williams
2 could have quit, and if so, why.

3 Is that somewhat cumulative of a couple
4 of questions I asked Dr. Raffle? Yeah, it is,
5 but given the length of this trial and what's at
6 stake, Your Honor, it's not unusual in products
7 cases and in medical negligence cases, and a
8 whole bunch of other cases, for a couple of
9 experts to get on the stand and basically opine,
10 bottom line, to very similar things.

11 And I do anticipate that this doctor's
12 direct exam is going to take me no more than
13 another half hour to present, so we're not
14 talking lengthy testimony on that point, but I
15 am acknowledging to the Court that there is a
16 cumulative aspect to the bottom line of
17 his opinion.

18 And I will be asking the Court's
19 indulgence to allow him, not so much to talk
20 about Mr. Williams being a nice guy, but to, in
21 fact, flesh out his understanding of the
22 witness's character -- excuse me, of the
23 decedent's character, Mr. Williams' character,
24 and his personality traits in total, so that the
25 jury can put this witness's understanding of

1 Mr. Williams as a person in a total package, so
2 that they can evaluate whether or not his
3 opinion about Mr. Williams' ability to quit
4 smoking makes any sense, and whether he has any
5 basis to give that opinion.

6 THE COURT: Well, I'm satisfied, first of
7 all for the record, that the witness should not
8 be permitted to testify under any nomenclature
9 of psychological profiling as it applies to
10 opinions he may be allowed to give as to
11 Mr. Williams, for the reasons I have indicated.

12 So now what we're looking at is what I
13 think, probably, Mr. Thomas, you were
14 anticipating to begin with, which was: Here's a
15 psychiatrist who's reviewed the records, who's
16 going to give an opinion about whether
17 Mr. Williams could quit or not, and he is
18 qualified to do that just like all the other
19 doctors who have commented on the issue one way
20 or the other.

21 Are there additional or any other
22 objections I need to consider in that regard?

23 MR. THOMAS: Well, the first one is,
24 Judge, that this is psychological profiling, but
25 without calling it creation of a psychological

1 profile, so --

2 THE COURT: It's an opinion, just like
3 the opinion that you've elicited about whether
4 Mr. Williams could have quit. You have lay
5 opinion and expert opinion in your case on that
6 subject. You have expert opinion from at least
7 Dr. Benowitz, and you've got the family.

8 You've got particularly compelling
9 evidence from Mrs. Williams that he couldn't
10 quit, that she was after him all the time, and
11 that he kept telling her that, so you've got
12 opinion evidence about whether he could or
13 couldn't quit.

14 MR. THOMAS: Actually, Judge, I think
15 that a careful review of the record would reveal
16 that Mrs. Williams was never asked whether
17 her -- in her opinion, Jesse Williams could or
18 could not quit smoking cigarettes. She was
19 never --

20 THE COURT: I'm not saying that she gave
21 a direct opinion. What I'm saying is, in your
22 case, a rational juror could conclude that his
23 entire family was very understanding of the fact
24 that he couldn't quit; that they had reached
25 that conclusion: He just couldn't.

1 And you've got a doctor who has offered
2 an opinion that he couldn't. I am saying -- I'm
3 adding those words "he couldn't," because
4 Dr. Benowitz has said -- at least Dr. Benowitz
5 has said, we've got other experts, too, that
6 have talked about it -- that Mr. Williams was,
7 quote, "addicted."

8 Now, there's no reason why a qualified
9 psychiatrist can't offer an opinion on whether
10 he was addicted, or to put it another way,
11 whether he could quit if he chose to quit.
12 That's really been the personal responsibility
13 argument all along.

14 You've told the jury, "We accept
15 responsibility for his choices, but we don't
16 think he made a knowing choice because he didn't
17 have a full picture when he chose to start
18 smoking."

19 And that's one of the clear things that
20 have gone forward. They're entitled to defend
21 against the assertion that he couldn't quit.

22 MR. THOMAS: Well, I don't mean to
23 quibble with the Court about that, but I do
24 believe that to extent that that is correct,
25 what was put in the plaintiff's case was just

1 rebutted in almost all their testimony by a
2 psychiatrist for this jury on both of those
3 areas, thoroughly, completely, and that this is
4 not only completely cumulative of that, but the
5 only way it's different is that it's based upon
6 this psychological profile.

7 THE COURT: We don't know that because,
8 first of all, we haven't heard what the witness
9 will say as to the basis of his conclusion that
10 he was no different from anyone else and he
11 could quit. That has not been asked of him in
12 the presence of the jury, number one.

13 But he wouldn't be on the stand if he
14 wasn't going to offer an opinion, a basis for
15 his opinion that Mr. Williams could exercise
16 free choice and was no different than any other
17 person.

18 Now, I've got some practical concerns
19 here. One is the hour of the day. We're about
20 to recess in 10 minutes. We can't even finish
21 30 minutes of direct. So I would like your
22 preferences about how you think we should
23 approach this.

24 I haven't yet made a final ruling on the
25 cumulative nature because cumulativeness also

1 bears on the schedule of the trial, it
2 absolutely does. And the extent to which this
3 is going to extend and extend the schedule we've
4 already sketched out for the week also bears on
5 what I have to figure out.

6 Now, I told everybody a while ago that we
7 have to recess early today. I reminded
8 everybody again Saturday, and it shouldn't be
9 any surprise that we're running up against an
10 adjournment time.

11 MR. DUMAS: If I may comment, first of
12 all, Your Honor?

13 THE COURT: He gets to go first, it's his
14 witness, and then you say something.

15 MR. DUMAS: First of all, Your Honor,
16 when I confidently indicated that I would finish
17 and rest our case by today, I, frankly, did not
18 remember the Court's reminding all parties about
19 4 o'clock, so that's --

20 THE COURT: I'm not talking about
21 resting.

22 MR. DUMAS: Well, secondly --

23 THE COURT: You don't have to
24 apologize --

25 MR. DUMAS: Okay.

1 THE COURT: -- for not being ready to
2 rest. It's ten to 4:00, that's the reality.
3 We're going to recess in ten minutes. What is
4 it you think you want to do?

5 MR. DUMAS: Here's what I want to do,
6 Your Honor. In light of the -- we don't know
7 the Court's bottom line ruling yet, but I'm
8 sensing --

9 THE COURT: Well, a lot of it depends
10 upon how long you're going to take --

11 MR. DUMAS: Okay.

12 THE COURT: -- because that has
13 everything to do with the cumulative nature that
14 you conceded in the witness's testimony.

15 MR. DUMAS: Okay. It is my intention,
16 Your Honor, of proceeding with about another 10
17 to 12, 15 minutes with this witness'
18 qualifications and practical experience, maybe
19 10 minutes, and then about another 15 minutes or
20 so talking about Mr. Williams, so I am
21 anticipating about 25 minutes more of direct
22 exam.

23 Here is my proposal to the Court, because
24 Counsel and the Court does not know this. I
25 have a -- we have -- the defense has a practical

1 problem, Dr. Turco is not available tomorrow.

2 If the Court is going to issue some
3 rulings regarding, which it already has, at
4 least to some extent, limiting this doctor's
5 testimony, then I'm going to need to retool a
6 little bit and cut things down.

7 I would propose that we utilize a
8 videotape presentation tonight of Dr. Turco's
9 direct exam and cross-exam, to be presented at
10 an appropriate time tomorrow morning, I assume.
11 Other than that, I have a real problem in
12 completing Dr. Turco's testimony. I cannot
13 complete his testimony prior to recessing.

14 THE COURT: Mr. Thomas?

15 MR. THOMAS: In that regard, I would like
16 to be given an opportunity to further inquire
17 about what is left of this doctor's opinion.

18 THE COURT: Here's what we're going to
19 do: I am going to allow Mr. Dumas to conduct a
20 direct examination on a video record, and for
21 you to cross-examine him, and then I am going to
22 be able to evaluate the extent to which it is
23 really new, or simply just a thumb print of what
24 we've already heard.

25 And how much time it's going to take to

1 play it to the jury. I am going to limit that
2 continued direct examination to simply straight
3 out opinion evidence about whether he did or he
4 didn't have the ability to quit if he had chosen
5 to quit, and what the bases are for that
6 opinion, because that seems to me to fall within
7 the expertise of this psychiatrist as well.

8 To the extent that is cumulative, I'll be
9 able to see it a lot better once we have got it
10 done. To the extent it is going to take a whole
11 lot more time, I can weigh that against what
12 time we have left.

13 And then you'll also have a chance to
14 cross-examine about the bases of the opinion to
15 see whether they are or they aren't psychiatric
16 diagnostic matters, or there is something in the
17 nature of the developing trend of psychological
18 profiling, the admissibility of which I've
19 already ruled out.

20 Now, if it proceeds on that fashion, can
21 you conceive of any prejudice to you tonight to
22 go forward in that way with me reviewing it
23 again tomorrow?

24 MR. THOMAS: Not in the legal sense.

25 THE COURT: That would be a no.

1 All right. I'm going to ask Mr. Rice to
2 go into the jury room and release the jury until
3 9:30 tomorrow. I have an 8:30 matter, and I
4 imagine I have to take this up at 9 o'clock.

5 And then before we lose this court
6 reporter, I want to see about what arrangements
7 you can make. Maybe you can bring a
8 videographer here and just -- you're all set up,
9 the witness is here, and do what you need to do
10 here. I don't know about the extent to which
11 you need this court reporter or not. Maybe we
12 can work this out.

13 THE COURT REPORTER: There usually is a
14 court reporter when there is a video deposition.

15 MR. DUMAS: I think we've made those
16 arrangements already for a court reporter at my
17 office as a backup in the event this happened.

18 THE COURT: Let's go off the record.
19 (Conference between Court
20 and counsel, off the
21 record.)

22 THE COURT: Let's go back on the record,
23 and let me just try to summarize where I left
24 this. I am sustaining plaintiff's objection to
25 any testimony regarding psychological profiling

1 or opinions based upon the developing art of
2 psychological profiling for the reasons that the
3 standards in O'Key have not been met on the
4 offer of proof.

5 I am going to allow continued direct
6 testimony and cross-examination of the witness,
7 based upon any opinions he may have, to a
8 reasonable medical probability on relevant
9 issues in the case, including whether
10 Mr. Williams was a person who was capable of
11 choosing to successfully quit smoking.

12 And to the extent of psychiatric opinions
13 are based upon the developing trend of
14 psychological profiling, I am going to be
15 inclined to rule those out, so perhaps a little
16 bit of planning on where you're going, and the
17 bases for what the witness can legitimately
18 provide you, can be fleshed out before we get
19 the videographer here.

20 And then the time that is consumed is of
21 concern to me in terms of its overall need, so
22 to the extent, we get to the point, there's less
23 of an argument that the cumulative nature is
24 really prejudicial, but I can't really judge
25 that objection until I see the whole record as

1 you're going to develop it.

2 So I am allowing the witness to testify
3 then in the video continuation of his direct
4 examination about the opinions he has drawn
5 about Mr. Williams' ability to choose not to
6 smoke, or to choose to quit smoking, and then
7 the basis for that are clearly exploreable on
8 cross-examination.

9 All right. We're off the record.

10 (Court adjourned, Afternoon Session,

11 3-22-99 at 4:00 p.m.)
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1 REPORTER'S CERTIFICATE

2
3 I, Katie Bradford, Official Reporter of
4 the Circuit Court of the State of Oregon, Fourth
5 Judicial District, certify that I reported in
6 stenotype the oral proceedings had upon the
7 hearing of the above-entitled cause before the
8 HONORABLE ANNA J. BROWN, Circuit Judge, on March
9 22, 1999;

10 That I have subsequently caused my
11 stenotype notes, so taken, to be reduced to
12 computer-aided transcription under my direction;
13 and that the foregoing transcript, Pages 1
14 through 119, both inclusive, constitutes a full,
15 true and accurate record of said proceedings, so
16 reported by me in stenotype as aforesaid.

17 Witness my hand and CSR Seal at Portland,
18 Oregon, this 22nd day of March, 1999.

19
20
21 _____
22 Katie Bradford, CSR 90-0148
23 Official Court Reporter

24 I certify this original/duplicate
25 original is valid only if it bears my red
colored CSR Seal. Katie Bradford

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